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Editor's Page

As ONE REVIEWS the papers submitted to the journal, one inevitably notices what appear to be trends in practitioner concern. For some time the swing in several professional publications, including this journal, has been toward articles on "process" (terminology being still regrettably unstandardized). There are relatively fewer articles on problems such as delinquency, alcoholism, and old age although there should be more.

The plain fact is that "content" has become respectable again. The issue—whether social work has or has not a unique content (knowledge)—even if true is not important because, in the modern world, it is not the sole bailiwick of any profession. In the slang of earlier days some schools of social work spoke of "content" courses and "method" courses, meaning such subjects as psychiatry and social welfare versus casework and research.[1] Content was equated with knowledge—for use, of course, but knowledge in some sense. Growth and knowledge are interlocked in professional purpose.

Social work is often accused of not having its exclusive treasury of scientific knowledge. This may be true, although we would not be afraid to claim that social workers know more about the use of money in family behavior than economists or bankers, more about foster homes and adoptive parents than many psychiatric clinics, more about delinquents than many judges. In the modern world knowledge is seldom uniquely held except in techniques peculiar to the profession. In the last few years social work has added to its store of substantive knowledge from psychiatry, from the social sciences, from law, from the beginnings of its own research. But to think of this forward movement as "borrowing" is as antiquated as for a doctor to write his prescriptions in Latin. Knowledge should not be in watertight compartments; it must be exchanged, shared, synthesized, integrated from many sources and disciplines.

Probably the unique thing about a profession appears in its cluster of technical processes. The distinctive character of social work process lies in its disciplined handling of the human situation; the basic configuration of "inner-outer," not merely as concept but as working model; the constant stress on worker involvement in intrafamilial and interpersonal relationships; the built-in use of the client's point of view. To elaborate on this last—for thirty-odd years professional attention has been given to the client responsibility and role; in planning treatment *with* rather than for the person; in accepting, supporting, and clarifying the client's investment in his own life situation. Professional attention, too, was given to client grievance committees as early as the Depression. Today there are interesting trends to elicit and utilize clients' attitudes toward social work role and program, leading to changes in policy or procedure.

All this describes, we believe, significant aspects of process. Other professions, no doubt, affirm the focus of the total person in the total situation but their practice does not often reflect this approach. In all social work process, practitioners consistently assume responsibility (especially now that the social component has been rediscovered) for "inner and outer," for human beings in their "total" relationships, including a two-way worker-client interaction. Like supervision, these insights—long familiar to social workers—may be our most important contribution to the cultural pattern of tomorrow.

Happy New Year to our dear readers and even dearer contributors!   —G. H.

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[1] This journal restricts the term *method* to denote the established methods of casework, group work, community organization within which process and professional tools are developed. For *process*, we find most useful the definition ". . . interaction of social worker and client, group, or community for the purpose of change" (see SOCIAL WORK, July 1958, Vol. 3, No. 3, page 111).

BY SAUL BERNSTEIN

Self-determination: King or Citizen in the Realm of Values?

PROBABLY SOME OF the most poignant inner searching among social workers has been and is around self-determination, which may be regarded as a technique, a fact, a cultural assumption, or a value. Many and apparently diverse meanings are attached to this concept. There is the deeply rooted sense on the part of social workers that building on the feelings and wishes of those served is essentially sound. On the other hand, many situations arise in which other considerations seem paramount. Just how determining should self-determination be? "Hard-to-reach" individuals, families, groups, and neighborhoods [1] throw up the question with force. They are not articulating requests for service. Under one concept of self-determination, we should leave them alone. The "hard-core family" on public assistance should receive the regular allowance to which it is legally entitled and nothing more, according to this position. The gang of teenagers creating aggressive mayhem should likewise be left to go its self-chosen way. Further illustrations could be multiplied, but it is more important to move on to the somewhat philosophic question rooted in and around the great idea of self-determination.

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It seems helpful to proceed—evolutionary fashion—from the simple to the complex. I shall start with a kind of one-celled notion and develop the theme into a complex organism of values.

SELF-DETERMINATION NO. 1

The heart and extent of this concept is that we as social workers should help people to do what they want to do and not stimulate them to go beyond their wishes. Self-determination is the supreme value, and it maintains its top position in any hierarchy of values, including those in which there are conflicts. For the worker the situation is pure and clear: help the people served to do what they want to do. There is little or no conflict between the values of the client and the worker. The latter's function is entirely devoted to providing the means and opportunities for the fulfillment of the desires of the client.

This position is clear and internally consistent as long as self-determination is maintained as the king value, with all others subservient to it. The working and meditating

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[1] Social work has no general term for the people it serves. *Client, group,* and *community* are commonly used. *Clientele* is perhaps an approach to generalization. In the "human relations field" there seems to be a growing use of the term *client system*. In this paper the term *client* will include individuals, families, groups, and communities.

hours of the worker are relieved of the tearing-apart kinds of conflict which beset devotees of other concepts of self-determination. But "Self-determination No. 1" is a simple soul who, if he ever existed, would not be helpfully related either to the practice of his profession or to the real world. There may be workers who sound as though they belong in this club, but usually one finds that questions bring forth many qualifications ("It depends," and so forth), so that the simple and pure notion of self-determination is soon lost. Essentially, however, this concept is basic and should not perish. Rather, it needs a special kind of company and context.

SELF-DETERMINATION NO. 2

Suppose we help a person do what he wants to do today, but tomorrow he wants the opposite. How do we know what he wants? By what he says? He may have been saying it for years without ever really acting on what he says. Ambivalence turns one straight path into at least two, going in different—sometimes opposite—directions. When a part of the client expresses a feeling and seems to reach a decision, the worker would be derelict if he moved quickly in this direction without devoting time, understanding, and skill to assessing whether this feeling and decision are in fact what the client wants, uncomplicated by other and even contrary wants.

Illustrations are common. A woman is so angry at her husband that she says she wants a divorce; as the situation unfolds, however, she shows much positive feeling and need for the husband, particularly if the worker is skillful in accepting her hostile feelings. A certain gang of girls made nasty remarks about a settlement house and everybody in it. They threw rocks at the windows, and unfortunately their aim was pretty good. Months later, after the worker had dealt with the girls and had come to know them well, she was convinced that the original hostile behavior was the method they used to ask for help from the agency,

without being able to put their need into words. Behavior was their language.

"Self-determination No. 2," then, recognizes ambivalence and nonverbal communication, and adds the dimensions of time and the worker's professional qualifications, so that the eventual decisions have increased stability, depth, and clarity resulting from some working through of conflicting feelings.

It is not always possible or even desirable to eliminate all conflict or ambivalence. Many situations have built-in and all-but-unresolvable conflicts. The client dealing with a chronically ill relative is doomed to mixed feelings. The unmarried mother is appropriately expected to be in conflict about the decision as to whether to keep or give up her baby. There is no satisfactory answer in the sense that it completely eliminates the appeal of the contrary decision or that no regrets will later be felt. People and life are not like that. But the contribution of the worker is around a new perspective on tense and mixed feelings. In assessing what the client wants and in helping him to achieve it, the aim is to take into full account the varieties of ambivalence and changes over time.

SELF-DETERMINATION NO. 3

Reality in its multitudinous forms enters the self-determination picture. It can be biological, as in principles of health. It can be economic, as related to a balanced budget (even installment buying requires that the payments be met). It can be legal, as in obeying laws. There are other forms of reality, but the essential point is the stubborn quality of it, which sets up rules and expectations not controlled by our clients, but which must be met by them. These factors narrow substantially the range of reasonable choices open to the client—and to us all. A man may want his public assistance allowance trebled and may be able to make a good case for the increase, but he is not the one who should or can make this decision. The same line of reasoning goes

for bad health practices, illegal behavior, spending well beyond one's income, and the like. A frequent problem faced by social workers is that many of those we serve have so weak a grasp on reality that they become enmeshed in its retaliations, and the client thereby loses the opportunity to express his self-determination in matters appropriate for it.

Reality has a fixed and final sound which can distort social work diagnosis and functions. The assumption is too often made that the client meets role expectations, that he "adapts," "adjusts," to his physical and cultural setting. The latter is presumed to be right, or rigid, something that does not lend itself to planned change. This is a strange position in a world full of dramatic and large-scale social, economic, and political change. C. Wright Mills in *The Sociological Imagination* makes the effective point that "nowadays men often feel that their private lives are a series of traps." These are large-scale societal changes which individuals do not understand or control. The writer pleads for "sociological imagination," which grasps the connection between the inner life of the individual and the larger framework of society.

This orientation does not give the client of a public assistance agency the right to decide on the amount of his allowance, but it does suggest that various social aspects of his situation might be examined and changed. Perhaps the agency should offer larger amounts, perhaps he can be helped to become self-supporting; perhaps there is a need for new economic institutions which will employ him. A crucial criterion for social change is whether it will increase the opportunities for appropriate self-determination for many people.

Returning to the original point about reality: the kind of exercise of self-determination that disregards reality is full of fantasy—it is unhealthy and self-defeating. A good part of the function of the worker may be to help the client distinguish what is fixed and stubborn from what is open to his decision. Skill in diagnosis inevitably involves the sorting out of what is relatively fixed from what is relatively changeable. Wise strategy of helping people to change is based on concentrating on what is most flexible. The client may still decide to flout reality (as all of us do at times), but then at least he will be better prepared for the consequences. It may well be that we can do our best work at the stage when the wallop of reality has been felt. There are great learning opportunities in such crises.

SELF-DETERMINATION NO. 4

Almost always, other people are involved in the self-determination of the client. His sense of responsibility may encompass them in varying degrees. There are instances in which parents abandon their children, husbands desert their wives, the gang beats up an innocent victim just to express feelings. At the other extreme is the person who allows himself to be exploited by others so that he is not making for himself the kinds of decisions that are the right of every human being.

Self-determination is enmeshed in a complex network of social relationships which move the notion far from the simple level on which each client does what he wants to do, yields to his own impulses. Even Robinson Crusoe was not completely alone psychologically or culturally. The problem then is to find some principles that will offer guidelines out of this maze. One might be that the exercise of self-determination by one person should have minimum inconsistency with such exercise by others. This is a kind of equivalent to the golden rule and Kant's categorical imperative. It does not eliminate all conflicts—not necessarily a desirable goal—but it does provide a helpful framework and even rather specific guidance. As a homely illustration, it is not rare for a club of adolescent boys to plan an affair involving a girls' club without much consultation of the wishes of the latter. The group worker can easily make the suggestion to ask the girls about some idea that is being argued. A large area of

potential contribution by social workers is embedded in this simple technique of consulting people who may be affected by a decision. How many times, in how many kinds of relationships, is this step omitted!

At the other extreme, with the person who is being exploited, the principle is rather different. The worker needs to diagnose carefully the areas in which legitimate self-determination is violated and then try to reinforce the client and influence the environment so that he may become able to enjoy the rights to which he is entitled.

With "Self-determination No. 4" we are in the midst of a question that has burned hot throughout much of human history. Egoism versus altruism is a kind of statement of it—a misleading one, I believe. Altruism asks for a kind of selfishness which seems unrealistic and unsound. Some of the worst acts of egoism have been perpetrated under the guise of altruism. The sense of selfhood is too deep, strong, pervasive, and instinctive to build on its elimination. More hopeful is the approach which recognizes and respects the drive toward selfhood in all of us, striving to help people understand how each can achieve identity only as he respects the same drive in others.

Many therapists have been so intrigued by the methods and orientation of their professions that they have overlooked the social dimension of self-determination. Individual dynamics are so intricate and fascinating that there is the temptation to regard them as all of significant reality. Perhaps subtly, the therapist is beguiled into an acceptance of what the client says about his social setting as being all that is important for the therapist to understand about it. The culture that has impregnated the client may be lost, as may be the impact of the client on the people he intimately affects. In just these areas social work has paid a price—the weakening of the "social" in its calling—for an otherwise fruitful dependence on psychiatry. It is a strange kind of ethic that elevates the desires of the client above those to whom he is socially related.

The "unseen audience" should not be victimized by therapy. Along with being an object of transference and other kinds of feelings, the therapist ought to be a kind of social conscience which helps the client relate his self-determination to all of those with whom he has relationships. To do anything else would contribute to social degeneration.

SELF-DETERMINATION NO. 5

Here we come close to the center of the human enterprise—to what, one may hope, distinguishes us from animals and from blind followers of instinct. A useful handle, much discussed in social work and elsewhere, is the process of decision-making. The infant when hungry "decides" to cry. It is a simple, instinctive reaction. A mature decision, at the other pole, is guided by rationality and intelligence. The learning of the ability to make the latter kind of decision is regarded by some as more important than the benefits which may accrue from any specific act of decision. Learning how to approach problems rationally is thereby elevated to the position of one of the most prized skills.

A whole flood of implications flows from "Self-determination No. 5." One is the growing concern about the probable consequences for oneself and for others from any given decision or action. Another is the need to attain sufficient perspective so that unconscious distortions and urges are kept at a minimum. Still another is the generation of a more or less conscious method for dealing with problems. In addition, there is the more thoughtful examination of previously assumed values. The list could be elaborated.

The content of intelligent decision-making has been given considerable attention by John Dewey and many others. The current human relations movement, with its ideologies and activities, is devoted to this end. In grand terms, it is the application of the scientific method to human affairs.

The social work client may be ready in

only modest and varying degrees to participate on these more rarified levels of human expression. Yet his self-determination takes on profundity only as he moves toward them. Each client needs our best diagnosis in terms of where he is and how far he can go, but the direction of change supported by the worker should be firmly derived from rationality. This may sound strange to those who strive so hard to understand all the perplexing irrationalities in people. But what is often overlooked is that the attempt to understand irrationality is essentially rational. Whatever concepts or constructs we may use to explain instinct-based behavior, they represent the struggles of intelligence to bring experience into some sort of order. The direction is clear.

The theme of freedom runs through this orchestration of the elements of self-determination. If one takes a pure and completely consistent deterministic position, self-determination is an illusion; it is simply acting in accord with controlling forces which may or may not be understood. In the Marxian context—*i.e.*, the idea that history is economically determined, especially in terms of class—the behavior of many of us would have to be considered a current and potent example of determinism; although that point of view leaves open the choice to join with the class that will presumably be victorious.

Social work is based on the assumption that people are free to make significant choices and that they can be helped to make better ones. But the attempt to use freedom to make decisions that are contrary to reality or largely irrational is self-defeating. Confusion rather than creativity flows from the disregard of facts and reason. Only as one takes account of the relevant factors does true freedom operate in decision making. Yielding to unexamined impulses is more a surrender to instinctive drives than the expression of mature self-determination.

This is not to claim that we are predominantly rational. Social work has dealt too much with raw ids to make this error. The orientation is rather to the effect that the

forces within and outside of us should be recognized and scrutinized with whatever rational capabilities we have. To help in this process is a major function of the social worker. Insofar as this help is successful, the worker is enabling the client to reach toward "Self-determination No. 5"—a pretty high level of social functioning.

SELF-DETERMINATION NO. 6

The subtitle of this paper, "King or Citizen in the Realm of Values," raises the question of hierarchy or priority. It is hoped that what has been said makes clear that self-determination is *not* king, or a supreme value. The various qualifications and contexts are meant to show that the mere act or desire to act according to one's wishes is neither a final nor a complete basis for a professional point of view. Assuming this position, are we left in a kind of "it depends" vagueness as to which values rise above others in specific situations and in general? I think not. Value problems cannot be reduced to the simplicity or specificity of administrative charts which show clearly who is above whom, but there are meaningful patterns and points of reference.

Most basically, the supreme social work value is human worth, an enormous idea, probably the greatest discovery in human history. Perhaps it suffers from too frequent mention in social work without sufficient elaboration of its rich meanings. It is based only moderately on what people are; much more on what they can be. It applies not only to those immediately before the social worker, but also to every human being on this earth (we may yet need an interplanetary concept). The specific content of the human worth idea evolves with history. It has many facets: legal and civil rights, standard of living, freedom to develop potentialities, intellectual and artistic interests, and others.

With this supreme value, self-determination then becomes modified. If what the client wants will result in the exploitation of others or the degradation of himself, the

worker should try to help him change his desires.

The steps suggested in this paper are meant to be criteria for judgments about self-determination which will help to place it appropriately in a hierarchy of values in any given situation. It seems more useful to approach the hierarchy question in this way (human worth at the top and self-determination subject to a set of criteria) than to attempt a rigid blueprint or chart. All this leads to the definite position that self-determination is *not* the king value, is not supreme in the realm of values.

CONCLUSION

While self-determination is not supreme, it is supremely important. Only through the rich utilization of this concept can we fully honor the human-worth value. This is in line with the best in democratic traditions. As we study and diagnose each situation, our concern should be for maximizing the choices for the people we serve, subject to the framework suggested above. Even with young children, there are appropriate matters about which they should be helped to make decisions. In an even more ex.reme example, the man in prison has many conditions imposed on him, but he might be helped to make his own decisions about jobs in the prison, recreation, what to do after he is released, and other matters. The point is that the value system of social work requires this maximization of self-determination.

In addition to its values, the methods of social work themselves require great stress on self-determination. People can be and are manipulated, but constructive changes which take root inside the person, group, or community usually need to be based on participation and consent. The Supreme Court decision on desegregation attempts to manipulate the environment—to eliminate by force the practice of discrimination in schools. It does not pretend to change the feelings of the prejudiced. Some have concluded that therefore this historic decision

is useless or harmful. I do not agree, and think that over the long pull the lessening of discriminatory practices can and does lessen prejudice. In the legal and perhaps other power-packed arenas, it is often necessary to override the self-determination of some people for the sake of human worth. The alternative would be to wait for complete agreement, an impossible political goal on most issues.

In social action, then, social work adapts its concept of self-determination to the realities of the process of political change; but the great bulk of social work practice has internal change as its goal. Here we find that imposing, telling, or giving orders do not work well. Only as the client is thoroughly involved and comes to accept on deepening levels the process of change can our methods be effective in relation to our goals. We may not be able to produce research-based proof (although there is some) for this position, but it is supported by so much practice experience on the part of so many of us that we fully accept and act on it.

There is a deeper and weightier support for self-determination: its existence and potency is a fact. Social workers and other professionals may enable, stimulate, impose, and even use force, but what the client feels, thinks, and values is ultimately his private affair and more within his control than that of the professional. The delinquent can be forcibly placed in a training school, but he cannot be forced to change his notions of the kind of life he wants to lead. For this the inner boy must be involved, must decide to re-examine himself and to change. This is a very important reason for emphasizing so much the significance of the relationship with the worker. Through it our boy learns to trust and have confidence in the worker so that he is ready to share some of his precious inward self with a view toward changing it. Only the boy himself can make this decision. Without his consent we can probably modify his outward behavior; with it there is the opportunity for changes in inward values, an essential and basic purpose of social work.

BY VIRGINIA LAURENCE AND ANNE BAECK

Voluntary Certification vs. the California Title-Licensing Bill

THE RECENT PUBLICATION of a proposed National Voluntary Certification Plan for social workers [1] is most opportune and will unquestionably provoke thought throughout the field of social work, especially in those states where legal regulation of social workers is being discussed and formulated. In one state—California—where a bill for licensing of title has been introduced into the legislature [2] there has been great difference of opinion as to the merits of this particular piece of legislation. The voluntary plan, differing in many respects but overlapping in intent, seems to highlight the crucial issues. Before entering upon any discussion of the two, it should be noted that the NASW Commission on Personnel Standards and Practices advises voluntary certification and sees it as the next logical step. It believes that the energies of staff should go into development of this plan nationally. It does not, however, view voluntary certification as a substitute for legal regulation, hoping rather that this will set a pattern that may later be enacted into law.

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The particular points at stake are not new. In fact, taken individually and outside the context of this specific state bill, one might find general agreement about them rather than an intellectual battleground. The paramount issue seems to be that, by contrast with other professions, social work is in an almost unique position of continuing to absorb people who have no preparation for social work practice. The majority of persons employed in social work have no social work education. Furthermore, social work has not been able to establish a standard for entrance into the profession which is practical and acceptable to employing agencies. This fact can be qualified and rationalized in a variety of ways, but it remains the most basic problem in circumscribing the social work profession. Teachers are certified, nurses are registered, and other professions use a variety of terms to indicate that the person has a fundamental justification for use of a title. This is not true of social work.

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[1] Proposed by the NASW National Commission on Personnel Standards and based on a study of legal regulation of practice by the Southern Minnesota Chapter (*NASW News*, Vol. 4, No. 2, February 1959, p. 24). Hereafter in this article referred to as the NVCP or "voluntary plan."

[2] The California bill, AB 244, introduced in January 1959, passed the state assembly, but was referred by the senate to an interim committee for further study on June 9, 1959. Hereafter referred to as the "state plan."

Since the first regulatory act to pass may naturally be used as a model by other states, this bill has taken on added significance. In like manner the voluntary plan, while not intended as a substitute for legal regulation, will surely influence future regulatory formulae. In the discussion that follows, specific provisions of the title-licensing bill will be contrasted with the other plan; the comparison will, we hope, help to crystallize some of the major professional issues in question.

COMPARISON OF THE TWO PLANS

Sponsorship by NASW immediately distinguishes the voluntary plan from state social work regulation programs in two important respects. (1) The former offers a uniform certification system for social workers all over the nation. Not only would this be an advantage to the profession in setting standards and goals for social work practice; since social workers are a mobile group, it is also practical. (2) A plan created and administered by the profession can best fit the needs of the profession. For example, the voluntary plan provides for facilities to be readily available for the study of qualifications problems that may arise; the California state plan, on the other hand, would be controlled by a board only three of whose seven members need have full professional qualifications.

The major issues in the California program may be subsumed under the headings of (1) professional standards and (2) revocation provisions. The comparison of the two plans lends itself to a similar analysis.

Standards. The applicant under NVCP must have the following qualifications: he must have had two years of graduate education, two years of NASW membership, and two years of supervision by a social worker already certified under the NVCP. By virtue of the fact that an application is required and that practice is not restricted by NASW, it may be termed a voluntary program. The remaining prerequisites are

intended to insure that the certificant have full professional education [3] and that his competence on the job be attested to by a social worker whose professional judgment the NASW has reason to trust. Lastly, the national plan would blanket-in those persons who have had two years of NASW membership and two years of experience at the time the plan goes into effect.

The applicant under the California state plan is compelled to obtain a license in order to make use of certain titles in the practice of social work for remuneration. It provides for three categories of social workers: (1) *certified* (with a master's degree), (2) *registered* (with one year of graduate education), and (3) *social worker*. The latter category requires no education or experience in social work, and passage of a merit system or civil service examination in social work would fall in this category. The title *social worker* therefore requires no demonstration of professional competence, and could not do so, since it licenses persons with no professional education. The state plan would absorb—without examination and into the categories for which they are eligible—all persons who consider themselves social workers and have been employed in social work for one out of the past five years; it would also take into the top, or certified, category all persons who are or will have become *registered social workers* before 1960. [4]

[3] Ernest Greenwood, "Attributes of a Profession," *Social Work*, Vol. 2, No. 3 (July 1957), pp. 48–49.

[4] This refers to a voluntary state registration program giving the title *registered social worker* to persons with one year of graduate education who apply and pass the examination. Registration was first proposed by California social workers in 1920, but not until 1928 was the first bill for registration proposed and introduced by the League of Women Voters. The California Conference instituted a voluntary program for social workers in 1932. It was not until 1945, however, that the legislature passed the voluntary state registration law, which has continued in effect until the present time. (Historical material derived from A. E. Arne, "Protection of the Public Through Licensing of Social Workers," *Social Work Journal*, Vol. 33, No. 4, October 1952, pp. 187–188.)

Revocation provisions. The voluntary plan, with its insistence on NASW membership, requires that a certificant adhere to the NASW Code of Ethics, thus establishing a relationship between professional conduct and certification. The state plan, however, sets forth certain grounds for revoking or suspending license to use the title. (This is not, let it be noted, a revocation of the right to engage in any specific type of work.) The title license may be revoked if licensee commits a felony, or uses liquor or narcotics to excess, or is convicted of a crime involving moral turpitude. He may also lose the right to his title if he advocates overthrow of the government by force or violence, or if he voluntarily commits himself to a state hospital. The only revocation provision which can be said to be related to social work practice is the one calling for revocation if he commits a dishonest or fraudulent act as a social worker resulting in substantial injury to others.

Summary. The essential and all-pervading distinction between the NVCP and the state plan lies in NASW's professional orientation. Its emphasis is on professional standards and practice. The state plan, on the other hand, applies to all persons employed in social work jobs, whether professionally trained or not, and attempts primarily to classify and register persons. The state, much as it may recognize the need for improvement of professional standards, must deal with the present reality. It cannot ignore the untrained worker.

The NVCP, as a voluntary program which does not restrict practice, will lend some prestige to the title of *certified social worker*. This plan appears to offer the most that can be hoped for at this time for the profession. In its interest in the trained worker, it may offer an incentive to the untrained to get professional education. Last, but not least important, the NVCP is not required to build into its design revocation provisions which in time of stress or hysteria might be applied without proper consideration.

DISCUSSION

In discussing the need for certification and regulation the NVCP and the state plan use some of the same terminology. Both speak, for example, of protecting the public and of improving the public's understanding of social work by affirming the qualifications and preparation of persons for social work employment.

However, a semantic problem appears to exist. In the NVCP, protection of the public is attempted by insuring that the certified social worker have a basic amount of professional education and experience; the state plan, while also claiming to protect the public, offers the title license to persons with neither of these qualifications. Similarly, in recognizing the need to improve public understanding of social work, the NVCP establishes a floor of professional qualifications; the state plan, on the other hand, informs the public that some persons eligible for title licensing have a certain professional background whereas others have none.

One must conclude that the two plans cannot with fairness be compared in the same terms. And since there is no magic by which possession of a license or a certificate makes one more qualified, a classification system not based on a set of minimum qualifications for practice does not really improve the public's understanding of social work or protect the public from the abuses of unqualified practitioners.

Is it possible for a state regulatory measure to be constructed which will establish a minimum floor of professional education or experience, as does the NVCP? The answer seems to lie in the fact that an effective plan for legal regulation for social workers has special problems which do not plague the NVCP. The NVCP can define a certified social worker in terms of his education and experience. Any legal regulation that restricts title—and thus to some extent practice—is meaningless without a definition of what one is proposing to restrict. Such a

definition—namely, what is social work—is still in the future. Moreover, a definition of social work is almost as essential to one further question that has to be considered when so many persons are functioning in social work jobs without the benefit of special education—that is, do all social work activities require the same degree of professional skill or education? If it develops that the need for social work education differs in relation to the job to be performed, the goal of assuring that social work activities are performed by persons with appropriate professional equipment would be more easily achieved.

However, one may say that any attempt now at legal regulation which excludes the untrained will be self-defeating; at the same time, a proposal that pretends to offer the public protection while extending professional status to the untrained is in some sense dishonest and will be opposed by the professional practitioner. Judging from the situation in California, where this dilemma has been adequately demonstrated, the profession is not ready for legal regulation.

In that state social workers without full professional education—or with none at all —appeared to support the licensing-of-title bill, which would have given them the legal title of social worker. In addition, many professional social workers joined in supporting the measure, feeling that it would improve their status or salaries; or that, through knowledge of the number and qualifications of those employed in the field, standards of education and practice might be improved. Some feel that "a bad bill is better than no bill"—in other words, that it was the best that could be achieved right now but could be improved later on.

Opposition to the California state bill came from (1) those who considered legal regulation unnecessary because of the control that social agencies exercise over social work practice; (2) those who believe that legal regulation is an appropriate goal for the future, but that present scarcity of trained workers makes it impossible to re-

strict title or practice to those truly qualified; and (3) those who opposed the specific bill for a variety of other reasons. Most of the last group objected to the low professional qualifications for licensing; to the fact that the Board of Social Work Examiners was, in majority, a nonprofessional group; and to the extensive blanketing-in provisions which favored a group formerly registered under the state Voluntary Registration Act, by placing them in the highest, or certified, category regardless of their professional qualifications. In addition, the provision which held that passage of a civil service or merit system examination in social work qualified one for the license (whether the person was accepted for employment or not), was a source of alarm to many social workers. In permitting such a substitution, social work would have abandoned to the Civil Service Commission the determination of qualifications for social workers. A number of workers objected to the revocation provisions of the state bill on the grounds that these were not related to professional practice and were so loosely defined as to be a danger to civil rights.

It appeared to some observers that, in California at least, social workers were apathetic toward the idea of licensing. While the bill was being formulated, meetings were scheduled for discussion but were poorly attended; few social workers knew what the bill contained or had a clear-cut opinion about it. In fact, opposition to the state bill, which resulted in deferment of its passage pending further study, became articulate only when the legislation seemed assured of passage. One could not help but be impressed that social workers—whose predecessors pioneered in social action—were reluctant to act even in a matter so directly affecting their profession. This apathy and indifference, if typical of social workers today, should concern the profession. It may be one of the dangers that accompany the profession's climb up the ladder of prestige. "The dilemma shaped in specific terms is how to achieve high prestige without giving

up militant social action and/or without losing identification with the people served, the clients." [5]

CONCLUSIONS

The NVCP is a plan that addresses itself to the fully trained worker. It has the advantages of being a single, national, voluntary, certification program that provides a basic standard of education and experience for the professional social worker. As such, it does not need to include categories for the untrained worker which might be embarrasssing or belittling. Neither will it detract from the status of the professional social worker by introducing confusion into the question of who does or does not have professional training. The voluntary plan can avoid these problems; they must still be dealt with by the profession.

The NVCP has another advantage. Professional workers will be happier with the Code of Ethics of the NASW than with a set of revocation provisions that have little relation to professional practice.

The state regulatory measure in California appears to have encountered many of the problems discussed in the Minnesota study.[6] A state plan cannot ignore the reality that a large number of persons in social work employment are untrained.[7] To include this group involves the danger either of wrath from the untrained, because they have been relegated to an inferior status, or of opposition from professionals, who object to being lumped with the untrained. As stated in the Minnesota study, "Our problem in protecting the public is not how to control the charlatan in our midst; it is rather, as we all know, how to train the untrained and how to raise the general level of our knowledge and practice." [8] It appears that neither the voluntary nor the state plan solves two problems most important to the profession—how to train the untrained who are constantly entering the field of social work, and how to acquire the status we deserve without losing an important heritage: the courage and responsibility to take leadership in improving society through social action.

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[5] Herbert Bisno, "How Social Will Social Work Be?" *Social Work*, Vol. 1, No. 2 (April 1956), p. 16. *See* Nathan E. Cohen, "Professional Social Work Faces the Future," *Social Work Journal*, Vol. 36, No. 3 (July 1955), p. 85: "Other professions are not caught up by the conflict in values in our society to the same extent as is social work, and, therefore, meet with less resistance in acceptance by the community as professional institutions." *See also* Grace F. Marcus, "The Advance of Social Casework in Its Distinctive Social Usefulness," *Social Casework*, Vol. 36, No. 9 (November 1955), pp. 396–397.

[6] Minnesota Study, *op. cit.*

[7] Nathan E. Cohen, "A Changing Profession in a Changing World," *Social Work*, Vol. 1, No. 4 (October 1956), pp. 18–19.

[8] *Ibid.*

BY HENRY S. MAAS

The Successful Adoptive Parent Applicant

THE CONCEPT OF social role is a potentially powerful tool in social work practice and research. Generally, social role is conceived, in Ralph Linton's terms, as the range of culturally derived expectations regarding behavior for all occupants of a given position or status in any social structure.[1] If for decades we have been studying the client-worker relationship, only recently have we begun to realize that this reciprocal, interactional process is in part determined by at least five sets of role-expectations: (1) what the client has come to expect generally of all persons in super-ordinate and possibly helping positions; (2) what he has come to expect, specifically, of persons in such positions in social agencies; (3) what his social groups have taught him to expect of persons, like himself, in the position of client; (4) what social workers in their training and orientation to agency have come to believe are appropriate behaviors and other attributes for a social worker; and (5) what social workers have learned from the professional culture are expected behaviors for clients.

This is not the place to amplify such formulations—to develop the proposition, for example, that the large numbers of "no-shows" and short-term cases we find in many casework agencies are often explicable, at least in part, as problems of role-ambiguity or of client behavior which does not permit of role-complementarity. Rather, what must be made clear from the outset is a belief which the data in our current study buttress. The professional subculture of social work defines some roles to which clients may find it difficult to adjust, coming from worlds sometimes quite remote from those which contribute some of social work's underlying beliefs and values. Moreover, caseworkers are constantly selecting clients in terms of agency policy on eligibility for services or otherwise, and in child welfare adoption agencies workers are in the position—with a child's placement at stake—to act upon their expectations for persons in the role of parent. It is adoption workers' charge to separate out, from amidst sizable numbers of applicants, those couples who fit the child welfare world's conceptions of adoptive parent from those who, given the children who are available, do not. Adoption workers ostensibly bring to this difficult task the most valid knowledge we have on parent-child relationships and family life. This they use in acting upon a now-narrowed and now-broadened range of expectations for the role of adoptive parent. But do these role-expectations vary across the country, from one region's subcultures to another? In nine widely dispersed American communities, do we find substantial variations in the kinds of couple chosen—among the *successful* adoptive parent applicants—that is, those who fit the agencies' image to the extent that a child is placed with them in adoption?

In this fragment of a much fuller story of children in foster care in nine communities across the USA, we shall describe our efforts at a kind of cross-cultural analysis of the reported characteristics of couples selected by agencies for the role of adoptive parent. Our intent was practical—to help locate parents for whom the child past the

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[1] Ralph Linton, *The Study of Man* (New York: Appleton-Crofts, 1936).

age of two years and/or the child who is physically, ethnically, or psychologically different is still an adoptive candidate. Our hunches were that older, intellectually dull normal, or physically handicapped children not acceptable to middle-class urbanites might still find permanent homes among the less (in-this-way) competitive parents of rural areas; that the ethnically different child had greater opportunities where he was a member of a numerical majority; and that the psychologically disturbed child was less a threat or mystery in the sophisticated upper circles of the big city.[2]

We cannot here go into the rationale for the selection of our nine communities. Of the nine, two were relatively prosperous rural counties, in North Central states, with populations under 20,000 and with county seats of about 6,000 population. Another two were small urban counties, in Mountain states, with populations of about 50,000, one prosperous and homogeneous, the other economically depressed and with 60 percent of its population Spanish-speaking. Three were metropolitan areas, all between 100,000 and 200,000 in population—one in the Old South with its restricted Negro segment constituting more than 40 percent of its city dwellers and lowest in economic rank; one in the Midwest, prosperous and homogeneous; and one in New England, relatively depressed economically and with a visible foreign-born population of over 20 percent. Finally, two were big cities, both close to a million population, both prosperous, one in the New South, 20 percent Negro and another 5 percent Spanish-speaking; the other and last of the nine, quite homogeneous for a big city.

A total of sixty agencies serving these nine communities dealt with 971 children in

adoptive placements between January 1 and June 30, 1957. Shooting for about 25 randomly selected adoptive cases in each community and drawing 100 percent samples in communities where there were fewer than about 25 adoptive cases, we were able to process and analyze the data in case schedules on a total of 187 of these children in adoptive placements, accommodated in 183 adoptive homes—with as few as 6 couples in each of our two rural communities and a maximum of 32 adoptive cases in one of the big cities.

Our analyses did not bring us as close to the dynamics of social role as we might have wished, but we touched on some of the biological, social, and psychological determinants of behavior in this position. We examined agency record data on the parents in each community along five dimensions that seemed relevant to the characteristics of children whom agencies placed—or might have placed—in adoption.[3] Thus we were interested in the parents first as biological organisms of given ages, degrees of health and reported capacity for having children of their own; second, as members of families of a certain size, residence, and history; third, as members of ethnic, religious, and social class groups, which in some measure, we assumed, determined their initial expectations and attitudes concerning children for adoption; fourth, as persons expressing certain expectations and attitudes regarding adoptive children; and fifth, as persons evidencing varying kinds of

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[2] The Field Foundation financed the larger study from which this paper is drawn. The study was done under the auspices of the Child Welfare League of America and under the research direction of the writer. This paper is an adaptation of chap. 23 of the report of the study, entitled *Children in Need of Parents* (New York: Columbia University Press, 1959).

[3] The limitations in our approaches to the problem of studying adoptive parents are apparent. For example, to answer basic questions about parents who might adopt unadopted children we should probably have studied also the adoptive parent applicants with whom agencies did *not* place children. We should also ideally have used far more refined measures than some of the gross devices in our case schedules for assessing parental adjustment. Note, also, that our data were derived from agency records, except where these proved inadequate and interviews were held with the caseworkers. In no case did we make any direct observations of the adoptive parents themselves. For a first broad survey of the situation, however, our study techniques seemed appropriate.

psychological reactions to their marriage, their childlessness, their plans for adoption, their own childhoods and their families of origin, as well as varying degrees of inner control in their expressions of feelings, ways of relating to other persons, and responses to the completion of tasks.

THE REPRESENTATIVE COUPLE

Despite the variations among our nine communities—in size and degree of urbanization, ethnic composition, economy, geography, and history—the modal portrait or profiles of all the adoptive couples in each community were remarkably alike. (The few notable differences among them are referred to later in this paper.) It is as though adoption standards in the child welfare field transcended in their potency any relevant differences among the nine community cultures.

Adoptive couple profiles in at least six, usually more, and often all of the nine communities coincided on each of the parental characteristics which make up the composite portrait of Jane and Harry Smith. The Smiths are the couple most often chosen in our nine communities. Their characteristics derive from 44 tables.

Jane and Harry Smith were both in their mid-thirties—Jane almost 34, Harry 37—at the time of our study. Neither had any health problem that would in any way interfere with their being parents to an adoptive child, but the medical reports were clear that Jane could never conceive a child of her own.

The Smiths were approaching a tenth anniversary of childless married life when the baby was placed with them. Neither had ever been married before. For the preceding five years they had lived in Castle Gardens, a post-World War II suburban development. Their two-bedroom house, valued at $12,500, was worth somewhat more than they had paid for it in 1952. What the Smiths had once called their spare room had in 1957 become the baby's.

The Smiths were both white and Prot-

estant, belonged to the same church, and were fairly active in it, according to their minister's letter. In the course of growing up, their adopted child was likely to find religion taking on considerable but not overwhelming meaning in his life. Education probably would be important for him too. The Smiths were both high school graduates for whom the depression years and then World War II, they said, had variously affected their chances for college studies. As a result, Mr. Smith thought he was not as far along in a career as he might otherwise have been. For eight years he has been working in a small advertising department, writing copy and doing layouts. Annual salary was "only $5,750," but Mr. Smith was expecting a Christmas bonus and then a raise starting with the new year. The Smith home on Strawberry Drive was compact and comfortable, with fifteen more years on a GI loan to complete paying for it. The yard was an easy one to keep trim, though there were always new home appliances and additional things the Smiths thought their house needed. Still, they both showed good sense and some humor about money management.

From the outset the Smiths were clear—they wanted only an infant for adoption. There was never any question either about their wanting the child to look as much like one of their own as possible, and this meant his having a similar nationality background, if possible. The interviews suggested that a minor remediable health problem in a child would not unduly upset the Smiths, but any evidence of psychological disturbance—and especially evidence that the child had less than average intelligence—would make a child unacceptable to them, since education and getting ahead seemed so important to them. Matters of the mind that were different from the normal were mysteriously troublesome, though such deviation as out-of-wedlock birth, known by the Smiths to be the likely background of any child they could adopt, came within the realms of their understanding and tolerance.

There had been little occasion in the Smiths' lives for them to learn at firsthand about psychological problems. Both were quite stable and relatively comfortable people, markedly content with their own marriage, having come to accept the impossibility of their having a child together and unquestioningly agreed that adoption was what they both wanted. Both looked back on their own childhood days and family life then as happy. While Mrs. Smith's parents and two sisters lived halfway across the continent, weekly correspondence kept their relationships a close one. And for Harry Smith, giving the spare room up to a baby meant some curtailment of his father's pleasurable, periodic visits from the city to Castle Gardens, but then other arrangements could be made when Mr. Smith, Sr., wanted to visit.

All in all, both Jane and Harry Smith seemed psychologically well within the range of the normal in regard to how they expressed their feelings, related to other people, and got tasks done. If they were in any way different from our image of average Americans, it was in the tendency they both had to behave as though the inner controls of principles or conscience guided their action somewhat more than did the forces of external circumstances. Personal flexibility was not a notable trait for either of them. With Mr. Smith the tendency toward self-restraint appeared in how he handled emotions and himself in personal relations. With Mrs. Smith imperatives were evidenced in the sphere of jobs to be completed. But these psychological uniquenesses were so slight as to be barely worth recording. The Smiths' capacities to weigh alternatives and act in response to both personal commitments and social demands were amply illustrated in the ways, once they were decided about adopting a baby, they went about inquiring into community resources for adoption and then maintained an understanding acceptance of agency procedures leading up to the placement of the baby.

VARIATIONS FROM THE SMITHS

While most of the adoptive parents in most of our communities resembled Jane and Harry Smith, there were, of course, many couples who differed from them in important ways.[4] The observed differences seemed related to our central question of the possibilities of adoptive placement for children who were somewhat older or different —other than in a minor, remediable physical difficulty—from the normal white infant whom the Smiths were counting on. Review of our data on both parental expectations and attitudes and on the characteristics of the adoptive children actually placed in each community—both predisposition and behavior thus becoming the bases for generalization—led us to some interesting propositions.

Older children—that is children of school age—were more frequently acceptable to the adoptive parents in the two communities where we found the largest proportions of farm owners or managers (33 and 26 percent) among the adoptive couples, and the two with the largest proportions of "blue-collar" and less-skilled workers (53 and 48 percent) among the adoptive couples. By contrast, older children were least acceptable—and tended to be least often placed —among the adoptive parents in the four communities with by far the highest proportions of professional, managerial, clerical, and other white-collar workers (from 66 to 71 percent of all adoptive parents). In addition, in three of these four white-collar adoptive communities we had essentially both no acceptance and no placement of children with below-average intelligence.

Liberal parental attitudes concerning the acceptance of children of mixed or minority ethnicity were expressed with some fre-

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4 While the roster of cases in each of the nine communities was randomly sampled to reduce to manageable numbers the cases for intensive study, the original rosters were in no sense samples drawn from a known universe; standard tests of statistical significance were therefore not used.

quency in four ethnically homogeneous communities. Fewer parents were so open-minded—and physical matching of child and parent seemed more often important —in cities where ethnic differences were, in fact, most visible in the population at large and where the largest proportions of ethnically different children in our study were actually placed in adoption. The proposition pressed upon us was that children of minority ethnicity might find some ready adoptive parents in relatively homogeneous communities where ethnic difference is not a threat.

Clear-cut interpretation of our facts on physical handicaps was not possible. Our adoptive parents did not seem to consider minor or remediable physical handicaps in children a barrier to their adoption, and, when we compared the numbers of children in foster care and in adoptive placements who had not-too-serious physical disabilities, we found no evidence that any but the most serious physical conditions *per se* kept children out of adoptive homes. On the other hand, in our four most prosperous communities we found large proportions of adoptive parents (25 to 44 percent of them) saying they would accept in adoption only a child who was physically perfect. In our economically poorer counties this factor rarely came up as an issue. Where we found the greatest wealth there seemed to be the most frequent insistence on childhood perfection in physical health. This is not to deny, however, that from one-fifth to one-half of the adoptive parents in these same four prosperous communities might have accepted a child with some minor physical anomaly.

Much more frequently rejected among our adoptive parents than the child with physical disabilities was the child with emotional disturbance. Evidence of a psychological problem among our children proved very definitely a barrier to adoptive placement with the kinds of parents being reached by the agencies in this study. In only the two largest communities was any

sizable proportion of the parents willing to consider the adoptive placement of a child with psychological problems. However, in the more prosperous small urban and rural counties, a fair number of parents would not have ruled out a child with such problems. Only 10 percent or fewer of the parents in all other communities remarked that they would be willing to adopt a child with symptoms of an emotional nature. Like being older than two years of age or having an IQ of less than 90, evidence of psychological upset was likely to bar a child from adoption with all but a very few of the adoptive parents under study—parents much like the Smiths who probably had never realized how children's psychological development is responsive to the kinds of certainty a home like theirs might offer.

THE "DIFFERENT" CHILD'S PARENTS

Since one of our major goals was to shed light on the problem of adoptive placement for older children and children who were different, we could not stop our search after a not-too-productive analysis of regional differences among our nine groups of adoptive parents. We therefore tried a second and, as it turned out, somewhat more fruitful approach to our data—a comparative study of all the adoptive parents who had taken children who were different with all the remaining adoptive parents of youngsters who were normal in every way. We found first that in 42 percent of our adoptive cases the children involved were in some way different. About half of these different children had some minor self-correcting or remediable physical disability. About 40 percent of them were of ethnic backgrounds different from America's majority. Fewer than a quarter of them gave evidence of some psychological problem. And exactly 8 percent of the children who were different were judged to have below average intelligence. Some of the children had more than one of these "differences."

Only these four factors—and not age—

were considered in defining the group of children who were different, but in effect almost all the children who were aged two years and over turned up in this special group. Among the children whom we constituted as our normal group, 95 percent had not yet reached their second birthdays, and the remaining 5 percent were under the age of 5. To this extent, then, our "normal" group was contaminated by the age factor. Our group of adoptive children with physical, ethnic, or psychological differences thus included all the children in adoptions who were five years of age or older.

Who were the adoptive parents of this latter group of children? Mary and Judah Albert represent the couples who were adopting children who were in some way different. Helen and James Q. Holt speak for the couples who adopted only preschool normal children.

The Judah Alberts were slightly older than the James Q. Holts. The Alberts were also married a somewhat longer time. The key to major differences between families like the Alberts and the Holts, however, was that in many more of the former (*i.e.*, families accepting "different" children) the fathers were skilled, semiskilled, or unskilled workers—all together, about half of them—while in about two-thirds of families like the Holts, the fathers were in professional, managerial, and other white-collar occupations. Related facts then fell into place: more men like Mr. Holt had had some college education (almost 50 percent); more women like Mrs. Albert had gone no farther than elementary school (15 percent). Mr. Albert was on his job longer than Mr. Holt, but twice as many fathers like Mr. Holt (about a third of them) had annual incomes, in 1957, of $7,000 or more. It was not surprising, then, that 15 percent of mothers like Mrs. Albert, after the placement of the child, planned to continue working—half full-time, half part-time, and most in white-collar jobs but some in skilled and service jobs—while only 2 percent of

mothers like Mrs. Holt planned to work, all of them in white collar jobs. Most of the working mothers were Negroes—and about a fourth of the adoptive parents whose children were different were not members of the majority ethnic group in our society but included persons of all the visible minorities in communities studied.

With their newly adopted child, the Alberts were a family of four; the Holts were three. While 80 percent of families like the Alberts occupied single dwelling units, as did 90 percent of families like the Holts, there were twice as many renters among the parents of children who were different. And the homes they owned, less expensive than the Holts', were also less likely to be in the suburbs, for a third of families like the Alberts lived in the city and another quarter in semirural and farm areas, while half of all families like the Holts lived in suburban communities. No matter, however, where either the Alberts or the Holts lived, they were to an equally high extent (80 to 90 percent) settled members of their home neighborhoods.

Also, both the Alberts and the Holts seemed with equally high frequency (in the 90 percents) to understand generally the place of heredity in a child's endowments. But twice as many families like the Alberts would accept a child of questionable background and 33 percent (as against 14 percent of couples like the Holts) would consider adopting a child who was ethnically different from themselves.

Couples like the Alberts clearly wanted a child. Three-quarters of them would not have let minor physical disabilities stand in their way and almost half would have considered a child with a mild emotional disturbance—though anything more serious would have been acceptable to only 10 percent of them. More than a quarter of these parents said they would take a child of between two and five years and another quarter said they would accept an even older, school-aged child—over half thus open to children above the age of two

years. Nor did the children have to be matched too carefully physically to please these parents. In all these ways, the Alberts' tolerances far exceeded the Holts'.

With such attitudes, Judah Albert's personality differed from Jim Holt's. For one thing, Mr. Albert was much less frequently than Mr. Holt reported to be a responsible party in the childlessness both couples had experienced. Moreover, Mr. Albert was less open in his expression of feelings, while Mr. Holt was more likely to be stricter about work obligations around the house and elsewhere.

As though to counterbalance the men, their wives tended to reverse these differences, Mrs. Albert being somewhat warmer when she was affectionate and angrier when she was angry than Mrs. Holt. Mrs. Albert was also somewhat less formal in her personal relationships and somewhat less concerned about getting chores completed.

Finally, while the Holts considered their coming to the adoption agency a matter of self-referral, the Alberts got to it quite deviously, through a chain of secondary sources, encouraged along the way by others to apply and, in this respect, too, most unlike the quite fully self-propelled Jane and Harry Smith of Castle Gardens. But then the Alberts had in the past known much more than the Holts or the Smiths of truly overwhelming experiences, during the depression years and at other times, so that, if they showed less apparent initiative in reaching such goals, they also evidenced more acceptance of who and where they were.

SUMMARY

In summary, then, while we found a surprising uniformity in adoptive parents selected by agencies in communities of different size, composition, and location, certain parental characteristics were related to the placement of other than normal

children. Older children seemed more acceptable to farm and blue-collar parents than to professional and white-collar parents. The latter had very low tolerances for children with below-average intelligence. In the more prosperous communities it was important that the child be physically perfect. In the more homogeneous communities, a child's ethnic difference seemed less threatening. In addition, compared with adoptive parents of normal preschool children, the parents of adopted children who were physically, ethnically, or psychologically different tended to be older, married longer, and of lower educational and occupational status.

Finally, it must be noted that our evidence on the initial expectations, at intake, of all our adoptive parents indicated more frequent parental tolerances for difference in adoptive children than the agencies' placements of adoptive children who were different made use of. This discrepancy held for the "barriers" of physical disability and psychological maladjustment but not dull normal intelligence —and here both parental tolerance and child placements were most infrequent. It held also for the age of adoptive children. Specifically, of the 183 adoptive couples under study: 61 couples expressed willingness to accept a child of minor physical handicap, but only 35 such children were placed in adoption with these parents by the agencies; 26 couples expressed willingness to accept a child with some psychological difficulties, but only 12 such children were placed in adoption with these parents by the agencies; 63 couples expressed willingness to accept a child aged 2 or over, but only 33 such children were placed in adoption with these parents by the agencies. One wonders therefore, whether it is not only the role of adoptive parent which agencies set but also, to a larger extent than we have thus far realized, the image of an adoptable child.

BY HENRY J. MEYER AND EDGAR F. BORGATTA

Social Agency and School As the Context for Studies of Mental Health: Research in Progress

MENTAL HEALTH AS a social problem now concerns far more than custody of patients in hospitals.[1] Expanding services and programs external to the mental hospital have increased the need for different types of research. Further, as prevention on the one hand and rehabilitation on the other become explicit goals, it is more important than ever to examine those settings within which mental illnesses occur and within which recovery takes place and is maintained.[2]

No contemporary theory suggests that mental illnesses occur in a social vacuum or as abstract disease entities. Mental illness occurs in the life of an individual as he develops in society, and thus the study of the etiology of mental illness cannot reasonably be detached from a study of the social setting in which it appears. Once this truism is stated, obvious questions follow: "What social settings are the important ones?" and "What social experiences are critical?" The former question must be answered before the more crucial latter question can be meaningfully attacked.

Two social systems immediately identified because of their sheer pervasiveness are the family and the school. Schooling occupies a considerable portion of time as persons grow and develop. The school experience with all its ramifications is necessarily relevant to subsequent mental health. This is even more evident with respect to the family, because it is both the locus of childhood experiences and an important part of adult experience throughout the life span. Viewed in this fashion, sociological study of these social contexts should receive increasing emphasis because such research can contribute to understanding mental health and mental illness.

Our current knowledge about the social factors in human behavior is not, however, at a level where one can specify the consequences of the course of experience in a social system for the subsequent mental health of a person. Indeed, we have difficulty speaking of the etiology of a mental

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[1] The range of interest is reflected in the contents of such recent publications as A. H. Leighton, J. A. Clausen, and R. N. Wilson, eds., *Explorations in Social Psychiatry* (New York: Basic Books, Inc., 1957); M. Greenblatt, D. J. Levinson, and R. H. Williams, eds., *The Patient and the Mental Hospital* (Glencoe, Ill.: The Free Press, 1957), R. Kotinsky and H. L. Witmer, eds., *Community Programs for Mental Health* (Cambridge, Mass.: Harvard University Press, 1955); C. G. Schwartz, *Rehabilitation of Mental Hospital Patients*, Public Health Service Publication No. 297 (Washington, D. C.: Government Printing Office, 1953).

[2] An equally important demand has been created for rigorous evaluative research. See *Evaluation in Mental Health: A Review of the Problem of Evaluating Mental Health Activities*, Public Health Service Publication No. 413 (Washington, D. C.: Government Printing Office, 1956). *Passim,* H. J. Meyer and E. F. Borgatta, *An Experiment in Mental Patient Rehabilitation: Evaluating a Social Agency Program,* (New York: Russell Sage Foundation, 1959).

illness because we frequently find it difficult even to agree on what the mental illness is.[3] Our knowledge is obviously still in a stage of exploration about mental illnesses, and we are prepared only to ask relatively simple and often very modest questions. We are not prepared to assert the elements that go into creating mental health rather than mental illness, but it is at least possible for us to ask whether certain modifications of the experiences of persons as they develop will have a meaningful and noticeable impact on aspects of their subsequent adjustment in society.

The research in process described here is of this type. It is concerned with the impact of a social agency in a preventive program that relates the agency to a school. The studies examine the possibility of altering patterns of deviance that have begun to manifest themselves and can be recognized within the setting of the school. The question to be answered is not the grandiose one of how the forms of deviance have arisen, but the more simple and direct one: "Can this social agency, with its best knowledge and application, make any impact on the deviant patterns of the clients it touches?" In order to answer this question, much careful and co-ordinated effort in research is required. However, such research may provide data that can broaden knowledge about mental health.

THE RESEARCH

This research should be considered an example, not a model, of the point of view expressed. It is a study of high school girls who, on the basis of their past histories, are judged likely to exhibit deviant behavior. The main task of the research is to assess whether the services of a social agency will have some effect in forestalling or preventing such behavior.[4] The central focus is evaluative. It is based on the comparison of a sample of adolescent girls referred and "treated" by a social agency with a sample that has been drawn by identical procedures from each of four entering classes of a high school. A brief description of the experimental design will indicate how the research is structured so far as evaluation of effectiveness is concerned.

Each entering cohort of high school girls is screened on the basis of school record information that comes to the school as part of the application process. By a series of general criteria, those in the class who appear most likely to get into difficulties are selected. This is a limited and superficial examination of the characteristics of persons in order to establish a pool of potential problem cases. A more intensive method of identifying problem-potential adolescent girls was considered. With the focus on evaluating preventive effectiveness, it seemed desirable to use only information that would usually be available rather than some special body of information collected especially for research.

The problem-potential pool of cases is identified from the entire cohort of entering girls on the basis of such criteria as the following: Do the elementary and junior high school records indicate unsatisfactory student-teacher relationships or difficulties in getting along with fellow students? Is there evidence that the school has identified misconduct or noted unusual conduct that suggests the girl had behavior or personality difficulties? What evidence is there of truancy, chronic absences, erratic attendance,

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[3] Beyond the question of diagnosis of types of mental illnesses, the meaning of mental illness as an identifiable phenomenon is uncertain. *See* W. A. Scott, "Research Definitions of Mental Health and Mental Illness," *Psychological Bulletin,* Vol. 55, No. 1 (January 1958), pp. 29–45; J. A. Clausen, "The Sociology of Mental Illness," in R. K. Merton, L. Broom, and L. S. Cottrell, Jr., *Sociology Today: Problems and Prospects* (New York: Basic Books, Inc., 1959), pp. 485–508.

tardiness, or similar violations of school protocol? Is there an obvious inconsistency between intelligence test scores and academic performance? Are there unusual fluctuations in intelligence or other test scores?

Some of the school records provide additional information on personal characteristics that are often considered indicators of emotional difficulties. For example: Are there references to anxieties, defiance, or tenseness? Is the child described as having difficulties with respect to physical appearance (such as obesity, cosmetic problems), restlessness, stuttering, or similar problems? Are there direct references to mental health, such as temper tantrums, depression, exceptional timidity, chronic dishonesty, or misconduct that seems directly related to the individual's personal characteristics? Among the routine ratings by teachers on personality traits, are there a large number of negative or unsatisfactory ratings? Finally, do the school records indicate some unusual family situation that might suggest difficulties for the child? School records are said to under-identify withdrawn, excessively quiet, or "pathologically good" children, and these selection criteria probably miss some such cases. This possibility can be examined from the testing procedures, described herein, for *all* girl students.

A school teacher who has some awareness of variations among adolescents could use criteria such as these to identify a portion of the class that appears more rather than less likely to face difficulties in the coming school years. Although this is a naïve approach to the identification of potentially unstable or deviant persons, it corresponds to the type of minimal consideration that may bring an adolescent to the attention of school or other authorities and to social agencies. In fact, this identification procedure is nothing more than a formal recognition of the kinds of information to which a guidance teacher or counselor gives attention in student records. In a practical sense, the adolescents so identified constitute a meaningful population for research attention. Conceivably, if we had sufficient information about prognostic indicators of mental health, we could specify more exacting criteria for selection of potential problem cases, but this is not the situation.

REFERRALS TO AGENCY

From the problem-potential pool of cases, girls are selected by a random procedure for the openings in the intake of the social agency. At the same time the referrals are made, a comparable group is randomly selected in accord with ordinary principles of control group design. During the four years of the experimental phase of the project 200 referrals and 200 comparison cases were selected.

One of the problems that has been faced elsewhere in evaluation research has been getting referred clients to the agency for treatment.[5] This constitutes a serious problem in research whenever the client is in a position to accept or reject the offer of treatment, whether within a hospital or in an external agency or service. Failure to solve the problem places limitations on generalizations that can be made, unless the agency is willing to undertake the full intake procedure before selection of treatment and comparison groups, a restriction that becomes prohibitive of research in most instances. In this research there has been unusual success on this score. Approximately 90 percent of the girls chosen as referrals completed the intake procedure with the social agency and received some attention. The combined efforts of agency and school account for this success.

The normal procedures of the agency have been adapted to the manner of referral and have been altered as a result of increased understanding by the agency of clients in this kind of situation. Customary case-by-case intake was unnecessarily cumbersome to deal with school referrals, and new approaches were developed. The

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[5] *See* Meyer and Borgatta, *op. cit.*, chap. 2.

most striking innovation has been the use of orientation groups to meet referrals collectively rather than singly. This was found to be an effective means of establishing an initial relationship between girls who had no serious, visible problems and an agency that sought to offer its services to them. It has also been found that both group treatment methods and individual casework were appropriate. From a research standpoint, the variety of methods by which the clients are provided service may permit comparative statements that otherwise would not be possible if uniform procedures had been insisted upon, regardless of the changing experiences of the agency.

The design of the project has necessitated frequent contacts between the agency and the school as well as between caseworkers and school teachers. From the viewpoint of the agency, in addition to anticipated and unanticipated administrative demands, the project provides a regular and stable source of clients. From the viewpoint of the school, a stable resource has been provided for students it would like to help. The referral of such clients to the agency has broadened the range of practice for the social work staff in two ways. In the first place, it has permitted attention to problems prior to their acute stage. Second, because of the inclusiveness of selection procedures, the normal range of problems of adolescent girls is more nearly represented, rather than the usual extreme problems likely to be brought to a social agency.

It should be emphasized at this point that the girls have no clear presenting problems from the viewpoint of the social agency. It is something of an innovation to refer girls who have been so casually identified as having potential problems to a social agency whose trained social caseworkers are accustomed to beginning with some problem brought to them by a client. This is not, therefore, testing effectiveness with the typical clients of the social agency, but rather inquiring into whether an earlier intervention can be effective. When one thinks of the problem of deviant behavior and of future emotional health in terms of prevention, the relevance of such subjects for research is unmistakable. Intervention prior to the identification of an acute difficulty that brings a person into a social agency is a critical part of the task of prevention of social deviance, mental illness, or emotional disability.

The implicit social and behavioral assumptions involved need to be underscored here: cases that constitute the mental health problems of the community are assumed to arise with greater likelihood among persons who have already shown some social or behavior difficulties. These cases can be identified in a general way both from records and by teachers and others who report the records. Some classes of test data, background experience, and other objectively available kinds of information in records may also serve as means of identification. General therapeutic attention given to the persons who are judged to have a high likelihood of becoming problem cases will forestall or prevent the occurrence. These assumptions avoid the problem of identifying specific mental illnesses and social behavioral problems, while suggesting that nonspecific treatment may have some efficacy. The setting in which potential deviance is observed is a natural one: the school. The nonspecific treatment is a kind of attention by social workers in a social agency that supplements the other kinds of attention adolescent girls might receive in the school, neighborhood, and elsewhere.

ADDITIONAL DATA ACCUMULATED

Although the focus of the research is the experimental evaluation of the preventive treatment program, around this central orientation a considerable body of data is assembled that may be utilized to provide other kinds of knowledge which may bear directly on the understanding of social and psychological factors in mental health. For example, the data collection procedures have been organized to accumulate data on

the *entire* entering group of girls at the school. By design, thus, every girl entering during the research period is exposed to the sequence of test and retest procedures that occur during each year as her cohort proceeds through the school. On a cumulative basis, the inclusive study population from the school will be approximately 1,200 high school girls. Thus norms against which the data of the referral and the comparison samples may be interpreted can be developed, and these data will also constitute a substantial body of information about adolescent girls that would otherwise not be available.

The following kinds of information are obtained at each testing: (a) the Junior Personality Quiz, a factor-analyzed personality inventory designed for use with adolescents; (b) the MAST, a sentence completion test designed to provide additional personality data; (c) sociometric data, based on a question as to what persons in the school the respondent "pals around with" or "calls her friends"; and (d) a brief questionnaire designed to assess the feelings and self-image of the respondent. In addition, at the first testing information is gathered on family background characteristics that are not consistently provided in the school records. Questions are asked concerning structural features of the family, such as whether it is intact or broken, and other questions provide data for an estimate of the social-economic status of the family. A number of the questions are designed to assess attitudes of the respondents toward their families in matters of discipline, independence, and other aspects of interpersonal relationship deemed relevant to an understanding of the family constellation. Another questionnaire is used in the final year of school in order to obtain data on how the girls regard the future and what their attitudes are toward school and their present situations.

Additional information is obtained from grade counselors, the guidance department, and other sources in the school. For example, data are collected about the discipline or conduct characteristics of the entire cohort of students. An index is constructed of the extent to which the school officials consider each member of the class as presenting some kind of a school problem, *i.e.*, primarily a problem of discipline. Indirectly, other kinds of behaviors are noted that may be treated as outcomes to which the variables obtained through the testing and data-gathering procedures can be subsequently related. Out-of-school behavior—such as difficulties involving the police, pregnancy out of wedlock, and institutional care—provides an opportunity for prognostic analyses. Although this is a by-product of the research, it may have considerable intrinsic interest at the same time as permitting tests of hypotheses about characteristics differentiating deviant persons from others.

As a terminal procedure for collecting data about the students, information is obtained from the records about school performance, academic and otherwise, so that comparison may be made with data collected at the earliest point of contact. Thus, in addition to school completion as one criterion of success or failure of the evaluation study, academic performance and the trend in the student's record, as well as performance on vocational job placements and immediate post-school situations, serve as criteria.

Through these many sources, data of a regular and orderly type become systematically available for the population of girls in the school. Gathered in this fashion, the data permit a longitudinal view of changes that occur during the high school years. The shifts that take place are important to understand, particularly in terms of information available prior to the occurrence of decisions and events that affect life patterns. It will be possible to examine, for example, the test characteristics of that portion of the high school population that drops out of school. This information is important because of the relationship of school career to subsequent deviant behavior. Insofar as

adolescents remain in school they may be viewed as generally conforming to the expected behavior of their age groups. School retardation and dropout are well-known concomitants of delinquency and other deviations. Whatever light can be thrown upon personal and other factors related to school dropout will in this way be relevant to an understanding of deviant behaviors.

With respect to the portion of the population referred to the social agency as the experimental group of the evaluation study, still other kinds of information that the social agency routinely records are available. These data are generally unstandardized, but they describe the treatment experiences to which the girls are exposed as recorded by the social workers. In addition, ratings from caseworkers and group therapists who have been seeing the clients are being collected. These ratings are intended to indicate the extent to which the experimental sample was involved in treatment and to provide some judgments from the professional social workers as to movement or change they perceive in the cases they have served. These professional judgments can be compared to the more external, objective criteria of change derived from the successive test measures.

CONCLUSION

This paper has been, in large part, an account of the kinds of information that are being collected in a systematic and rather extended study. We see the approach of the research as meaningful for the study of mental health and deviance because it focuses on a group that has high likelihood of getting into trouble, and in addition embraces the population from which this group is selected. It affords the opportunity, furthermore, to examine some consequences of intervention within the potential problem group through a control-group design. The longitudinal character of the study is just as important as the evaluative aspect. Data become available to examine what factors become predictive of subsequent difficulties.

If we are to understand the elements that enter into deviant behavior or mental illness, it will be necessary to obtain longitudinal data that start, not with the present deviants and work backward, but rather with normal persons and work forward. The school is a particularly strategic institution within which to develop this kind of study.

Although the number of persons who come in contact with social agencies is limited, here, too, is a setting of considerable importance for understanding problems of mental health. Aside from the hospital and the school, the social agency makes perhaps the most important deliberate effort in the community to affect persons who are having emotional or social difficulties. Our study concerns the possible preventive, rather than the ameliorative, effect of the social agency. Whatever effect is examined, however, the treatment programs of agencies constitute reflections in practice of theories of behavior, and evaluative researches should thus shed some light on these theories.

The point of view represented by this research asserts that the actual situation of the person is relevant when viewed in its social context. In this instance the school and the social agency are the points of observation. On this assumption, two lines of inquiry are encouraged. On the one hand, the testing of practice and its implicit theories of behavior through careful control-group studies, and on the other hand, the accumulation of knowledge about the development of the normal and deviant patterns of behavior through systematic longitudinal studies. In the latter case the emphasis does not lie on testing specific theories of behavior, but rather on examining plausible relationships that need to be explored, and for which general theoretical suggestions serve as guides to classes of data that should receive attention. Further progress in understanding social and mental health cannot stop with plausible theory but will rest on the cumulative body of empirical knowledge.

BY JANET STAPLES MUNT

Fear of Dependency: A Factor in Casework with Alcoholics

WORKERS IN THE field of alcoholism have been impressed by the alcoholic's wish for dependency and his regressive longing to have his needs taken care of without consideration of reality. The discovery that alcohol can provide a sense of security—a mental and physical warmth and comfort which, for a while, alleviates the pains and tensions of interpersonal relationships—marks the beginning of compulsive drinking. As the drinking increases, the alcoholic grows increasingly dependent on its effects, until eventually all other interests disappear and his only relationship is with the bottle. He is then like the infant who alternates between the states of hunger and satiation and, like the infant, is consumed with rage when his needs are not met. Only when intoxicated can he feel relief from tension which, for the alcoholic, apparently is peculiarly intolerable. Larger and larger amounts of alcohol are required to achieve and maintain an illusion of well-being, until finally he is reduced to a state in which even alcohol gives no relief.[1]

Analysis of alcoholics has shown that an unsatisfied need for the all-giving, nondemanding love of the earliest mother-child relationship is at the core of alcoholism.[2] This extraordinary need for dependency is certainly not incompatible with one of the conditions of the casework relationship; namely, that the patient develop some form of dependency on the caseworker which becomes a part of the positive transference and within which he can face his problems. Theoretically, therefore, when an alcoholic has become sufficiently concerned about his drinking to come for help, one should be able to anticipate an initial ready acceptance of treatment. In practice, however, one often finds the opposite: a great reluctance and resistance. It is the writer's contention that this resistance is partly based on an intense fear of the dependency for which the alcoholic longs, and that the dynamic reasons for this fear must be ascertained and dealt with immediately if one is to save the treatment opportunity. To illustrate, I have chosen two cases, one which barely got beyond the intake process and one which developed into long-term treatment, but each of which demonstrates the mechanism of this fear. Neither were "successful" cases in the sense that the treatment goal of sobriety was accomplished, and in retrospect it is felt that had the clinic team been sufficiently aware of the fear of dependency concealed behind the wish, the outcome might have been different.

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[1] Georgio Lolli, "Alcoholism and the Love Disposition," *Quarterly Journal of Studies on Alcohol*, Vol. 17, No. 1 (March 1956).

[2] Otto Fenichel, *The Psychoanalytic Theory of Neurosis* (New York: W. W. Norton & Company, Inc., 1945), pp. 375–380.

CASE 1

The patient was a 37-year-old married sales-man with two children. He was the second son in a family of three boys, the youngest being a stepbrother. His father had died of tuberculosis when the patient was six months old. His mother remarried soon afterward and his stepfather died when patient was four. Again his mother re-married, and this stepfather died when the patient was six. His two grandfathers also died during these years. As a boy, there-fore, he lost five fathers or father figures. His only opportunity for masculine identifi-cation was with a sadistic uncle. The patient gave up school at age 14 and began a selling career. He was drinking regularly by 16 but he stopped in his late teens. At age 20, he married a girl two years younger than himself and began drinking again a year later. A son was born three years after the marriage and another five years later.

Vocationally, the patient had apparently been successful, despite constant moving about the country. Things went reasonably well in the marriage until eight years ago when his brother, four years his senior and a salesman like himself, moved in with them. This brother was alcoholic and, even though older, was said by patient to look on him "as a father." The patient was aware that this relationship with his brother somehow marked the beginning of his excessive drinking. He felt that his brother was dependent on him and this was intolerable; actually, it would appear from the material that the reverse was true; *i.e.,* that he felt dependent upon his brother. The patient began to drink more heavily, but the brother sought psychiatric treat-ment and through it maintained sobriety. As the patient talked about his brother's sobriety, he became extremely anxious and insisted that this was not the reason he was stopping drinking; that he did not need to depend upon the example of anyone else to accomplish this. Behind the obvious denial one could see that the patient looked

on his brother as an example—a person who could stop drinking—but he was afraid of depending on this image; afraid because his brother might disappoint him and drink again and then he, too, might be destroyed by brother's drinking. When his fear of being dependent upon anything was pursued with him, the patient revealed that as a child, he felt that any dependency he formed with a person was somehow "forced" upon him; that is, was dangerous. "Life wouldn't be worth living if I should accept that I was dependent upon something."

It was impossible to get the patient to discuss his relationship with his wife and children. It would seem as if this whole area was too painful for him to talk about. Interestingly, his wife was eight and a half months pregnant when he came for help. Undoubtedly, the fact that there was about to be one more with whom he must share his wife as well as one more to depend on him was the precipitating factor in his coming to the clinic.

When first seen as an outpatient he was so tense and shaky, so near tears, that com-munication was difficult for him. He proudly proclaimed that all his life he had never been to a doctor until "unable to get around." He felt, however, that his drink-ing had "caught up" with him and he was concerned about his physical condition. Obviously he was in poor health and just as obviously there had been progressive social deterioration, with decrease in his earning power and ability to fulfill his role as a husband and father. Immediate hos-pitalization was indicated and one might have thought it would have been welcomed by him but he refused adamantly. He was not intoxicated, he desperately wanted help, but he could not accept the first and obvious recommendation. This was not entirely out of a wish to continue drinking. Two reasons seemed to stand out: (1) his in-ability to stay in any one place for any length of time, an almost "manic-like" behavior which had persisted for years and

which possibly was related to his constant moving around as a child; (2) his enormous fear of dependency—fear of dependency in any form, whether on a hospital, on a drug, or on another person. He equated his coming for help with "going to the executioner." Three interviews were required during which his fear of dependency was carefully explored and then recognized with him before he was willing to be hospitalized. During the patient's stay in the hospital it was discovered that he had tuberculosis and he was told the diagnosis by his physician. When he was faced with the implications of this, that is, with an even longer period of hospitalization and dependency, his old fear got the upper hand. He insisted on being discharged, gave up treatment, and went home. When heard from four months later, he still was unable to do anything about his tuberculosis or his alcoholism.

It would seem as if this man's fear of dependency was related to the loss of father and father substitutes during his earliest years. Taunted by fate, so to speak, he was bereft of opportunities for normal male identification and left yearning for dependency on a man. Because of the repeated losses, dependency came to be felt as dangerous, and he defended himself by denying the need. His alcoholism helped to maintain this denial as well as gratifying the wish. It decreased his tension and anxieties and gave him a sense of euphoria and feeling "all one."

The patient's initial fear of hospitalization for alcoholism and his subsequent and insurmountable fear of going to a tuberculosis sanitorium could be understood as an attempt to avoid the intolerable situation (for him) of being dependent on someone (the institution) and thus re-experiencing the original trauma he had experienced as a child: sitting around helplessly, watching people die. In this case, the patient's developing tuberculosis was a complicating factor; without it, treatment might have continued.

CASE 2

The patient, a 33-year-old woman, was the youngest in a family of eleven children, of which the four next older than she were boys. Her father was alcoholic, a "jack-of-all-trades," and a poor provider who apparently was somewhat deteriorated by the time patient was born. He was spoken of in a deprecating and negative way by the patient throughout most of her treatment. Her mother apparently was the typical long-suffering wife of an alcoholic who held the home together by dint of her own neurosis. She was consistently and sympathetically portrayed by the patient as worn out, having no love "left over" after so many children and such a husband. Whatever affection mother had to give, patient felt was given to the boys; there just was not enough "mother to go around." The main theme in her life history was a longing for something from mother which she felt she never had and which, in fact as well as fantasy, she probably never did have.

The patient's childhood was marked by material as well as emotional deprivation. She was painfully aware of the poor conditions in her home and her family's lack of status in the community. She recalled many unhappy memories, all of them reflecting a lowering of her self-esteem.

The patient menstruated for the first time at age 13; her mother gave her alcohol for dysmenorrhea. Interestingly, her mother apparently did some drinking herself until age 33 (patient's age on coming into treatment) but then stopped for unknown reasons.

Upon graduation from high school, the patient joined the Navy and it was there that her social drinking began. When she was discharged, she returned to the parental home. There, for the first time in her life, she had her parents, primarily her mother, to herself; all the other siblings had married and left. She got a job as a clerk-typist, gave her money to her mother for whom it meant the first "luxury" that she had ever

known; *i.e.*, the patient tried to "improve" mother so that she would be more of a mother (her fantasy mother). By reversing positions she made a child out of her mother and tried to show mother how she should have acted toward her. This had tremendous meaning for the patient who recalls it as the happiest time in her life. It would seem as if she had tried to make her mother into the kind of mother she longed for; that both consciously and unconsciously she tried to build up a new image of a mother on which she could depend. But this was short-lived, for six months later her mother became ill and died. With her mother's death, in patient's own words, "The rafters shook." As she told about this it seemed as if she felt it to be final conclusive rejection by her mother; all the worse, because she had done everything she could for her mother but mother left her just the same. It was at this point that the patient's drinking began to be compulsive, and she suffered a severe depression. On several occasions she took a bottle to the graveyard and drank it while sitting beside her mother's grave. During this period she became closer to the younger of her two sisters, twelve years her senior. She developed a dependency on this sister but two years after her mother died, the sister died of kidney disease following childbirth.

Shortly after the loss of this mother substitute, the patient took an apartment with another girl. The relationship, which became overtly homosexual, lasted three years and was terminated abruptly by the other girl who chose another partner, a girl who lived with her mother. The patient's girlfriend had apparently been the active one and it was patient's first overt homosexual experience. She did the cooking and in general played the "feminine" role. Obviously, she had recreated a mother-child relationship. She described the three years as, again, "the happiest in her life" although she drank to excess and she described her feeling at the loss of this girl as one of despair. Again she suffered a severe depres-

sion. Quite consciously she equated this loss with the loss of her mother; *i.e.*, with mother's death, "The rafters shook"; when the girl left her, "The roof caved in." She then began drinking until blacking out. She embarked on other short-lived homosexual affairs interspersed with attempts at living with various married siblings. She had several jobs during this period. The year prior to her coming into treatment, she had lived with her eldest brother, age 53, and his family. She had somehow held a good job as a clerk-typist and it was her employer who referred her to the clinic. She was drinking daily, periodically so much that she could not go to work. In her brother's home she re-experienced much of the pain of childhood. Her brother drank as her father had and her sister-in-law was as ineffectual and ungiving as her mother had been.

When first seen as an outpatient, the patient was defensive and had difficulty talking. After two interviews she stopped coming and was not heard from for a month. She then came, severely intoxicated, and accepted being admitted to the hospital which is in the same building as the outpatient department. While in the hospital, she developed a rash which necessitated her remaining longer than usual, the hospital obviously representing a place where she would be "taken care of."

After discharge, she continued to come almost daily to the unit (the combined hospital and outpatient clinic and "therapeutic community" which outpatients are allowed to visit at will), even frequently coming on her lunch hour to eat her sandwich there and returning after work to stay as late in the evening as allowed. Clearly, the unit had become "home." She said as much, and her coming was coming home to mother; *i.e.*, to mother's house. She attempted to draw out her interviews as long as possible at the same time that she protested, at least in the beginning, the need for them; and she sought contact with the caseworker outside the interview situation

as much as possible. She constantly tried to force the caseworker to be something else.

However, in the eight months of treatment, during which she was hospitalized six times, the intense wish for dependency gradually emerged as but one side of the conflict. She also feared it. This wish for and fear of dependency were partly demonstrated by her drinking and repeated hospitalizations and partly also by her verbalizing, at first in disguised form and then directly, her anxiety about what would happen if she depended on the caseworker. In all the material she brought to treatment, this fear of dependency was dominant. She seemed to be saying, "If I let down my defenses, do I lay myself open to attack, to again be rejected?"

The picture was complicated by the fact that the caseworker was pregnant which recreated the home situation to the extent that it reminded the patient that as a child she was not the only one. She complained bitterly to the nurses about the pregnancy and how too bad it was that the caseworker should have children when she could do so much for people like herself. She did not acknowledge awareness of the pregnancy directly to the caseworker until a few weeks before the latter's leave of absence. But the week before the interruption in treatment was to come, the patient drank and had to be admitted to the hospital. This, on the one hand, brought her physically closer to the caseworker; *i.e.*, she would come and live with her in "her house" which reassured the patient; and on the other hand, it was a conscious and unconscious testing of whether the caseworker would reject her; *i.e.*, leave her.

During the first month of the caseworker's leave of absence, the patient remained sober but phoned the caseworker at home several times a week, always at night as though "to be tucked into bed." While the caseworker was in the hospital for delivery, the patient phoned almost daily and came once to see her. Two weeks after the caseworker

returned home, the patient got drunk and was re-admitted. The patient's acting out was dealt with then more vigorously than before by pointing out to her that she was repeatedly testing the caseworker and that the latter was aware that her fear of dependancy was driving her. The patient saw this intellectually and also, occasionally, emotionally. However, this was not sufficient and she had to be rehospitalized only ten days after her discharge. It was felt that to continue treatment might have disastrous effects for her in terms of social deterioration, loss of job, and so forth. It was decided, therefore, to terminate treatment. The interpretation which was given the patient in various ways and over several interviews was that, "In a way I am leaving you but not as your mother did, or your sister, or your girlfriend; but in order to help you because you are destroying yourself in the process of testing me. You can depend on me in terms of the understanding I have given you." The patient protested violently as was expected; but, significantly, since the termination of treatment four months ago, she has remained sober. She has in no sense been cured but it would seem as if by the caseworker's refusal to participate in her acting out, she was sufficiently reassured, at least for a time, to overcome her fear of dependency and to remain sober. Terminating treatment seemed the only way to accomplish this, since the patient lacked strength to resist acting out and it was, therefore, impossible to work through her deep fears of dependency.

CONCLUSION

In casework with alcoholics one must always steer between the wish for and the fear of dependency. We are accustomed to thinking of the alcoholic's need for dependency mainly in terms of the wish, but there are many cases in which the fear is of primary importance. One might go so far as to say that the intense wish for dependency is always partly a denial of the fear.

On the deepest level, the alcoholic's fear of dependency is the fear that he will lose his identity, almost that he will melt into the other person; therefore, he defends himself as though against some instinctual danger which, for him, being dependent represents. The form of this fear may vary from early running away from treatment, as in the first case, to coming into treatment and then acting out the fear in various destructive ways, as in the second. In dealing with such cases it is imperative to see the form of this fear and then deal with it immediately if treatment is to be successful.

In terms of method one might say that whenever strong dependency needs are evident in the initial interview, they should be carefully explored as part of the presenting problem, even at the expense of not obtaining other historical material. This should be done keeping in mind the fact that fear of dependency may be expressed in many ways, directly or indirectly, but most frequently in connection with the idea of coming for help. When the latter is true, it is only after some of the anxiety surrounding the fear has been relieved by recognition, discussion, ventilation or other supportive techniques that the patient will be able to accept direct intervention such as hospitalization (and go through with it), or be likely even to be able to return for subsequent interviews. More difficult are those cases in which dependency needs are not prominent initially and/or the fear of dependency is hidden beneath an obvious intense wish for dependency. In these the fear may emerge only after some attempt is being made to modify the adaptive behavior patterns of the individual by uncovering the reasons behind the drinking. When it does emerge, however, it should be handled like any other negative transference manifestation, mainly by clarification accompanied by appropriate supportive techniques.[3]

It is suggested that special awareness and sensitivity is required in order to handle successfully the alcoholic's fear of dependency. Since it is the relationship between the caseworker and the patient which is the core of treatment and since it is precisely such a relationship that the alcoholic fears, some modification in treatment techniques appears necessary. Much needs to be learned but one thing seems advisable: meticulous care should be given to keeping the strength of the transference, especially anything which would strengthen its dependency aspects, at an absolute minimum. This poses a technical problem since alcoholics, *ipso facto,* need to be given to more than most nonalcoholics. Although not illustrated by the case material, the use of an ancillary service or an interested person or group such as Alcoholics Anonymous, as an adjunct of treatment, has value both directly for the patient and as a means of diluting dependency on the caseworker.

To summarize, we must incorporate the concept of the wish-fear of dependency into our body of technical knowledge about alcoholism, make some modifications in treatment techniques, but then use this knowledge skillfully in the traditional casework relationship—the medium through which the alcoholic patient, like all others, is to be helped.

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[3] Community Service Society of New York, *Method and Process in Social Casework:* Report of a Staff Committee (New York: Family Service Association of America, 1958), p. 19.

BY ROBERT E. THOMAS, JAMES H. GILLIAM, AND DOLLIE R. WALKER

Casework Services for Alcoholics in a Magistrate's Court

THE STRAIN OF everyday living is so acute that escape from it takes many forms; among these escapes excessive drinking plays a prominent part. During such a crisis, an individual's behavior can become so bizarre and offensive that he is frightening not only to his family but also to the social agencies who should serve him. The mental health movement in the state of Maryland, realizing the dearth of resources for this needed group, has devised one means of being creative in assisting them. One experiment was the establishment of a casework service in the Magistrate's Court where the problem drinkers could face the reality of the problem and choose professional help or refuse it.

In this paper we shall describe, (1) the origin of the need for this casework service, (2) the use of the caseworker, (3) the specific survey objectives, (4) method and techniques of measurement, and (5) findings and conclusion. The reader should be reminded that this paper is an assessment of a casework service for alcoholics. No attempt will be made at this time to put forth fully the specific function of the caseworker, nor the use of authority in dealing with this kind of a problem. The latter would make a paper in itself.

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The Northwest Community Project on Alcoholism was initiated late in January of 1954 as a demonstration service of the Division of Mental Health, Maryland State Department of Health. Establishment of this service grew out of concern shown by an interested group of citizens and the Maryland State Department of Health about the possible relationship between the high incidence of crime in the northwest section of the city of Baltimore and the problem of alcoholism.

Discussion among the citizens and the health department representatives suggested that both excessive drinking and the criminal offenses—at least in part—might be a reflection of the social, economic, and emotional problems of certain defendants coming under the jurisdiction of the magistrates. The direct approach to the problem already available through use of the court's facilities seemed to require additional services if the high rate of recidivism was to be countered. On this basis, casework service provided by highly qualified social workers with administrative experience was seen as one method of assisting the court with this problem. Such an arrangement was therefore instituted at the Northwestern Police District Court. At the outset, it was agreed that casework services would be offered to selected defendants having drinking problems. Goals for this pilot program were considered as being educational and preventive, as well as therapeutic.

USE OF SOCIAL WORKER

The social worker was assigned to the court on a part-time basis to offer help to

alcoholics, which included work with their families. The worker was purposely made available to these clients on weekends because it was felt that this time period was the crucial one for this type of caseload. Too, the workers involved could only assume this kind of responsibility on weekends because of their work responsibilities. All had regular jobs the rest of the week. The social worker assigned to the Magistrate's Court to offer help to the alcoholics had a twofold function. First, he was there as a member of a team (magistrate and worker) to screen cases of persons appearing before the court who were problem drinkers and, second, to provide casework for those who seemed to need the service and appeared to be able to use it. It was found that the drinking problem in many instances was the underlying cause rather than the actual cause for the arrest.

The social worker attempted to find out in an interview with the defendant whether or not he saw drinking as a problem, and was willing to accept help to resolve his problem.[1] If and when this was established, the judge could continue the case for a designated period, subject to review, with the understanding that the defendant would explore the service further with the worker on a continuous basis. This step would be taken only after the interview in which there was sufficient indication that the defendant wanted help. The social worker would let the defendant know what the decision entailed, such as time and place of future appointments and consequences of not following through on meeting the requirements of the service. The social worker's knowledge of alcoholism, as well as resources in the community, made him a valuable adjunct to the court as a consultant in other situations. His primary reason for being in court was, however, founded in the belief held by the Department of Health that many cases in their incipient stages could be helped if profes-

sional casework help was offered on a sound basis.

The alcoholic (or person with a drinking problem) was defined as a compulsive drinker whose life had become unmanageable through the uncontrolled use of alcohol. Casework was conceived as a process of helping within the confines of the State Department of Health, Division of Mental Health, with the referrals screened at the Magistrate's Court. Casework was dependent upon the conscious use of the relationship that developed between the client (drinker) and the caseworker. Skill in deepening and developing this relationship was the worker's strongest tool. He (worker) used this relationship to help the individual with a drinking problem to bring about a change in himself to the extent that he no longer considered alcohol as essential to his living.

The applicant was met by the worker in the second interview with what he brought to the relationship: fear, distrust, anger, disgust, loneliness, and a feeling of being different and apart from others. He was allowed again to choose this service. If he wanted to explore it further, the caseworker through scheduled interviews for a given period of time would seek to help the applicant take some responsibility for his drinking problem. The worker let the applicant know that the problem may not lie entirely in himself, but may involve his relatives. Social agencies, as will be seen later, were also utilized.

After the project had been in operation for a period of three years, the Division of Mental Health, Maryland State Department of Health, initiated a survey of the program which forms the basis for this report.[2] The over-all objective of the survey was to determine the adequacy of the service in reducing recidivism among those persons appearing in the Northwest Magistrate's

[1] Defendant becomes the applicant if he states he wants to use the service.

[2] Special recognition is given to the help of Dr. Stanley D. Imber, and Anthony R. Stone, M.S.S.W., consultants to the Division of Mental Health, Maryland State Department of Health.

Court and who indicated a willingness for help. It was also believed that the survey would provide a basis for future program planning.

SURVEY OBJECTIVES AND METHOD

The objectives of the survey were: (1) to evaluate client benefits derived from the service as measured by five independent criteria; (2) to evaluate current problems and needs influencing the effectiveness of the project in the community; and (3) to make recommendations for future planning.

The records of all clients served during the period from September 1, 1954, through April 30, 1957, were surveyed by means of a specially adapted schedule, devised by the Division of Mental Health to assess its county alcoholic rehabilitation clinics. This schedule covered the following: (1) identifying data, *e.g.*, sex, age, marital status, and occupation; (2) duration of the casework service; (3) collateral contacts, including relatives and community agencies; (4) reason for termination of service; and (5) independent criteria of improvement or change. Each client's record was examined individually and data abstracted for the completion of the schedule. These data included not only the content from case records but also information obtained from the files of the Central Record Bureau of the Baltimore City Police Department.

FINDINGS

Identifying data. Eighty clients were seen during the period covered by this survey. At the end of this period, 74 cases were closed and 6 were currently receiving service. All cases were referred from the Magistrate's Court of the Northwestern Police District. The clients were male, ranging from 15 to 72 years of age, the median age being 33 years. Sixty clients (75 percent) were married, 8 (10 percent) were single, and the remainder were divorced, separated, or widowed. Seventy-five clients (94 percent) were employed at the beginning of casework service. The majority of those

employed were laborers, of whom 20 (25 percent) were skilled and 47 (59 percent) unskilled. The remaining 8 (10 percent) were employed in professional and semi-professional fields.

Offenses of clients brought into court. The number of offenses totaled 85. This is greater than the number of clients, since some were charged with more than one type of offense.

Type of Offense	No.
Assault	35
Disturbing the peace	17
Disorderly conduct	20
Found drunk	12
Larceny	1
Total Offenses	85

Although most of these offenses were not linked in the record with the drinking problem, testimony showed that they were related to the inability of the clients to drink alcoholic beverages with social restraint. The largest percentage, for example, was for assault, usually directed against clients' wives, whose testimony often indicated that the spouse did not behave this way when sober.

Casework duration and attendance. The 74 closed cases averaged approximately 10 weeks of contact, as did the 6 active cases, both active and closed cases extending over an average of about 6.5 interviews.

In addition to the above regularly scheduled interviews, 54 of the clients had unscheduled contacts which consisted of home visits in 34 cases and special appointments in 23 others. There were an estimated 300 telephone contacts made during the period covered by the survey.

Contact with relatives and community agencies. In 63 cases (79 percent) relatives were seen on a regularly scheduled basis from one-half to one hour every two weeks as part of the planned program for the client. Contacts were extended in duration and frequency in cases where spouses or relatives were able to see the value of the service for the clients and/or themselves. No

TABLE 1. COMPARISON OF CLIENTS WHOSE RELATIVES WERE OR WERE NOT INVOLVED IN CASEWORK

	Relatives Involved	Relatives Not Involved	Total
Drinking (amount and/or frequency) as compared to initial status			
Abstinent	11	2	13
Much less	26	1	27
Somewhat less	17	3	20
Unchanged	7	11	18
Somewhat worse	2	0	2
Much worse	0	0	0
Out of control	0	0	0
Family and social adjustment as compared to initial status			
Better	44	4	48
About the same	15	13	28
Worse	4	0	4
Occupational adjustment 1. Present work adjustment of those employed at the beginning of casework service			
Better	14	0	14
About the same	36	12	48
Worse	0	0	0
2. Present work adjustment of those unemployed at the beginning of casework service			
Better	10	2	12
About the same	3	3	6
Worse	0	0	0
Physical status as compared to initial physical status			
Better	40	2	42
About the same	21	15	36
Worse	2	0	2
Conflict with the law 1. No. of entries in police records prior to beginning of casework service	107	44	151
2. No. of entries in police records after the beginning of casework service	46	20	66
Difference between Items 1 and 2	61	24	85

relatives were seen in 17 cases (21 percent) although efforts were made to involve family members if available.

Fifty-two collateral contacts were made with community resources, in a total of 34 cases (43 percent). Minimal use was made of community agencies because project services were conducted on a part-time basis, during evening hours and on weekends,

when the agencies were usually not open. The agency most used was the Police Department, which was contacted on 10 occasions (19 percent) because of its personnel's familiarity with the client and his family. Other collateral contacts included police magistrates, 9 (17 percent); Alcoholics Anonymous, 8 (15 percent); employment service, 6 (12 percent); private welfare, 4

Services for Alcoholics in a Court

(8 percent); family physician, 3 (6 percent); public welfare, 2 (4 percent); and Legal Aid Bureau, 1 (2 percent). Other resources contacted were the Baltimore Urban League, landlords, psychiatric clinics, selective service, and the state's attorney's office.

Reasons for termination of service. Thirty-seven (50 percent) of the inactive cases were closed because the client had received maximum benefit; 12 (16 percent) because the client refused the service; 9 (12 percent) because the caseworker felt that the service was not needed; 7 (10 percent) because the client was referred to another agency; and the remaining 9 (12 percent) for miscellaneous reasons.

It is interesting that, of the 12 clients who refused service (although the social worker felt the problem existed), 7 were among those whose relatives were not seen.

Client's improvement or change. Improvement in drinking problems (decrease in amount and/or frequency) was noted in 60 cases (75 percent). Two cases (3 percent) were found to be worse, while 18 cases (23 percent) remained unchanged. Examined also were changes in the area of family and social adjustment, occupational adjustment, and physical status. As can be seen in the following data, generally positive changes occurred in these areas also.

In analyzing these results, it was found that 48 cases (60 percent) showed improvement in family and social adjustment, 28 (35 percent) remained unchanged, and 4 (5 percent) showed regression. At the time casework service began, 62 persons were employed, 14 (23 percent) reflected improvement in their occupational adjustment, 48 cases (77 percent) remained unchanged. Eighteen persons were unemployed at the beginning of service, of whom 12 (67 percent) obtained employment while 6 (33 percent) did not. Forty-two clients looked better and real improvement was seen in their physical status; 36 (45 percent) remained the same; 2 cases (3 percent) grew physically worse. It is interesting to note that 48 clients had no conflicts with the law after casework service began. Further, in all cases, conflicts with the law [3] (as measured by number of entries in police records) were reduced by more than 50 percent. For example, police records indicated that there were 90 less entries after casework service than before. In 158 entries before service began, there were only 68 entries once service was under way or had ended.

IMPORTANCE OF INCLUDING RELATIVES

Table 1 highlights the importance of including relatives in a treatment program. Fifty-four (86 percent) of the patients whose relatives were included in treatment showed improvement in their drinking patterns, whereas only 6 (35 percent) improved whose relatives were not included.

Generally on criteria other than crime the advantage of having relatives in concurrent treatment is reflected in the superior improvement rates of the patients. The following table indicates the number and percentage of clients who improved on the basis of four criteria, which were: (1) drinking (amount and/or frequency), (2) family-social adjustment, (3) occupational adjustment, and (4) physical status.

TABLE 2. NUMBER AND PERCENTAGE OF CLIENTS WHO IMPROVED

	No. of Clients Improved	Percentage of Clients Improved	Cumulative Percentage
All four criteria	19	24	24
Three criteria	21	26	50
Two criteria	15	19	69
One criteria	10	12	81
No improvement	15	[19]	
	80	100	

As shown in Table 2, 50 percent of the patients improved on three or more of the four criteria; 7 out of 10 improved on at least two criteria.

[3] Equal periods before and after initial contact were utilized. For example, if at time of survey a period of six months had elapsed since the beginning of service for the clients, then the police records for this six-month period were examined and compared with the six-month period immediately prior to the beginning of the service.

DISCUSSION

As an adjunct to the court, this casework service has attempted to assist in reducing recidivism among persons appearing in the Northwest Police District Magistrate's Court for offenses associated with excessive drinking. The survey indicates that generally positive results were achieved. Seventy-six percent of the clients seen had fewer arrests after receiving help than had been the case prior to that experience. Even more impressive is the finding that 60 percent of the clients had no subsequent contact with the law at all during the selected project period and up to the time of survey (the time in individual cases ranging from six months to three years). It appears from this study that casework services are valuable and economical to the client and his family, as well as to the community in general.

It should be emphasized that beneficial aspects of the service were not limited to the clients themselves, nor was improvement gauged only by amount or recidivism or frequency of drinking. Especially in cases where spouses were included in the casework plan, positive results were found in family and social adjustment and occupational adjustment, as well as in drinking and conflicts with the law. However, considerable benefits were also derived in most situations where family members were not included.

The indications of improved personal, social, and economic adjustment of the clients and their spouses are reflected in many ways. For example, new levels of satisfaction in recreational and cultural activities were also reported by the clients. This study illustrates that as clients and their families gain sufficient confidence to accept responsibility for their problems, they are able to take on other responsibilities required of good citizens in the community.

Because of the limitations implicit in a part-time service, the workers in the project exercised great care in the selection of potential clients for the service. Working at a serious disadvantage in terms of time that could be spent in eliciting co-operation from other social agencies in the community—especially in view of the antipathy that almost universally exists toward the alcoholic—the social workers in collaboration with the magistrates were forced to limit eligibility to those who gave some evidence of stability and who had family members or relatives available and interested in their welfare. Reflecting this careful selection as well as the authoritative setting with which the service was identified is the finding that, of the 85 persons selected as suitable candidates, only 5 failed to appear for their appointments. In this sense, the authoritative atmosphere provided by the court setting seemed to have a significant therapeutic value for this type of case. There are indications that more thought and study should be devoted to appraising other situations where authority has been used effectively for persons with drinking problems.

Another aspect of the success of this service may be found in the timeliness of the help offered. For a person with a drinking problem it is important that assistance be offered at the actual time of crisis. Not only are such individuals generally avoided when they seek help, but often the policies of the agencies to which they apply for guidance actually tend to reject the alcoholic entirely. In one sense this casework service was a demonstration of the therapeutic effectiveness of attention given to a troubled person at a critical period when other services are not available.

In spite of the positive aspects of the service described above, the partial rejection of help by some clients, as well as failure to carry through on the part of some of the applicants once casework service has been initiated, still constitutes a problem which merits continued thought and planning. Ideally, the service described in this report might well be part of the municipal court system, and in time apply to a wider range of potential clients coming through the courts.

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BY ROBERT K. TAYLOR

Identification and Ego-directive Casework

ONE PURPOSE OF social casework is the redirection of personal behavior along lines conforming to community expectations. Although the manifest function of casework may be described in somewhat different terms, its latent function is almost certainly to persuade the client to conform to the cultural models of behavior of his community and society. Inevitably caseworkers influence their clients in some manner, since both they and the clients have values, explicit or implicit, which intrude into and affect the casework relationship. If the caseworker recognizes what values are operating within himself and within the client in a given casework situation, he will be better able to manage these values in behalf of the client. Values in such a situation are a potent tool of the casework process.[1]

SOCIAL ROLE THEORY

In what is termed "social role theory," the social psychologists have formulated a useful instrument for the analysis of behavior, one which commends itself to caseworkers.[2] Every individual learns to perform certain

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roles, socially defined by the society of which he is a member. When he learns to perform these roles as they are supposed to be performed—and does so comfortably and with satisfaction to himself (one might say by "second nature")—he is said to be "well socialized." Everyone beyond infancy performs a great variety of roles. A school child presents one facet of personality to his parent, another to his teachers, still another to a peer playmate. Each interpersonal experience involves a separate reciprocal role relationship. The role of superior is complemented by the role of subordinate, and the roles of husband-wife, teacher-student, employer-employee are other illustrations. Roles specify rights and duties which belong to a particular social position. They indicate to whom one has obligations and upon whom one has a rightful claim. The customary behavior in each role helps to make social interaction an orderly process. Mastery of a role involves internalizing the social norms appropriate to it.[3]

[1] *See* Robert K. Taylor, "The Social Control Function of Casework," *Social Casework*, Vol. 39, No. 1 (January 1958) for a fuller discussion of the points raised in this paragraph. *See also* Robert Merton, *Social Theory and Social Structure*, rev. ed. (Glencoe, Ill.: The Free Press, 1957) for a discussion of manifest and latent functioning.

[2] *See* Ralph Linton, *The Study of Man* (New York: Appleton-Century-Crofts, 1936), particularly chap. 8, "Status and Role." *See also* Ralph Linton, *Cultural Backgrounds of Personality* (New York: Appleton-Century-Crofts, 1945), pp. 75–82.

[3] *See* Theodore R. Sarbin, "Role Theory," in Gardner Lindzey, ed., *Handbook of Social Psychology* (Reading, Mass.: Addison-Wesley Publishing Co., 1954).

In most casework situations there is a fair degree of congruence between the internalized social norms in the client and the general social norms in a majority of the community. The mutually reinforcing roles of wife and mother, of husband-father, and of parent-child are widely known in the community. Dr. John Bowlby, child psychiatrist of the Tavistock Clinic, London, discussed in a meeting at which the writer was present the twenty-year-old girl, independent, relatively free of responsibilities, earning a good living for herself, spending a high proportion of her income on clothes, cosmetics, and other egoistic items, who is transformed during one short year into a married woman with a new baby, sacrificing her "singleness" and her single living standard, "requiring very great sacrifices for twenty-four hours of the day, every day of the year." [4] All this necessitated tremendous psychosocial change within her. How can this be possible, Dr. Bowlby asked? This is possible, one may answer, because the girl carried within her a conception of the roles of wife and mother. These role conceptions, embodying social norms, values, and attitudes, had been internalized during the years of her socialization from early childhood. She knew how to perform these roles and derived satisfaction from surrendering the advantages of singleness and assuming what would, in another context, seem an unconscionable burden, because she had acquired the appropriate social role conceptions of her community.

This is not to suggest that every client seen in a casework agency will have acquired his social roles in the sense of Dr. Bowlby's illustration. In fact, many of our clients are persons who have not learned their roles properly or are in role conflict. Every client is a unique instance. Some are obviously less adequately socialized than others. A clue to this kind of client problem which may require psychiatric evaluation

and treatment is the presence of substantial incongruity between the client's behavior and community expectations for one of his age, sex, social class, and other circumstance.[5] For the psychotic patient the world of reality—which comprises the behavior patterns, values, motives, roles, and statuses of the community—is not the world in which the patient lives psychically.[6]

The problem is to help the client gain or regain the world of reality ("regain," since in most cases the client will have known aspects of the "real world" at some time in his past), and to help him, by re-education through psychotherapy, to face living in it and coping with its problems.

Through socialization and the acquisition of role conceptions, people learn to communicate with each other, since they share common understandings as to what is appropriate behavior in any given situation—"appropriate," of course, in the sense that it conforms to community norms and standards.

SELF-INFLUENCING IN CASEWORK

In application of role theory to casework situations, the caseworker has a good bag of tools to begin with, whatever the specific setting. There is typically a state of apprehension and tension in the client. He is usually aware that he has a problem, although his awareness may be expressed symbolically, or otherwise indirectly in

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[5] Taylor, *op. cit.*

[6] John Dollard in "The Psychotic Person Seen Culturally," *American Journal of Sociology*, Vol. 39, March 1934 (pp. 637–648) wrote, "From the sociological point of view a psychotic person may be seen as one who has rejected existing social organization and developed a compensatory private version of culture. Up to the point of psychosis our hypothetical person accepts group valuations and meanings and responds to persons and objects in a way which is intelligible to us, therefore within the range of the 'normal'. . . . After the psychosis, our common frame of reference is to a greater or lesser degree discarded. . . . He rejects or interprets the ordinary social texture of expectations of action and substitutes his private definitions of situations and preferred ways of behavior.

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[4] British National Conference of Social Work, Bedford College, London, April 1953.

terms of symptomatic manifestations. He sees the caseworker as a helping person. He imputes power to the caseworker.[7] He sees casework as a tension-relieving therapy. He wants, indeed requires, the help the caseworker has to give. He is in a situation where he may be influenced to the utmost by the caseworker.

In a good casework relationship, the client comes to influence himself through the superego, the "generalized other,"[8] or social and moral conscience. The caseworker is a facilitating agent in this self-influencing process. The client "talks to himself" with the help of, and through, the caseworker. The caseworker's participation may be in verbalizing for the client the latter's own thoughts and attitudes. The caseworker is identified with the community in the client's mind. The community as represented by the caseworker and the community as internalized by the client in his role conceptions are both present in the casework situation; hence its power to effect changes in behavior.

The client is a social being. He has been thwarted in integrating his psychic needs and the demands of the external social world. His world is off-balance as compared to the world of others around him. He is not getting the picture properly focused. In addition, the client's emotion about his problem serves to inhibit his effective use of whatever intellectual competence he may have to understand and reduce the area of imbalance.

While he talks to the caseworker, he talks also to himself. The client who can

express in the casework setting his love for the wife with whom he has shared a history of marital conflict is influencing himself and reinforcing his positive feelings for his wife. Every caseworker can cite instances of this kind of verbal reinforcement and self-influencing activity. The caseworker, agent of the community which is the client's external social world—the real world which he is to be helped to face and from which he may have temporarily strayed in some degree—then represents the client's "best self." The client will hear himself when he ta'ks to the caseworker. The caseworker may not have to tell the client (in most instances it may be best if he does not) what he should do about the problem facing him. In a real sense, the client probably knows already. But he may not have access to this "knowledge." The caseworker's task is to help the client gain access to what he "knows" already: such knowledge as will help him tackle and solve the problem he has brought.

Some students of learning theory may object that, if the client does not have access to what he "knows," then he doesn't know it. But for our purpose the helping art is to free the client, clear away inappropriate defenses, and give him courage and strength to summon up and make effective use of his inner knowledge and resources. The sometimes spectacular gains in knowledge and competence in our clients suggest that in many cases it is a problem of freeing knowledge previously inaccessible.

An incident from a case history may help to illustrate this. Mr. and Mrs. J had sat rather stiffly before the caseworker during the interview. They reported an unhappy marital situation. Their quarrels had become more frequent and usually ended in great bitterness. Neither had been tender and loving to the other in several months. Both were miserable. Mr. J responded by excessive drinking and loss of interest in his job. His wife responded with nagging and recriminations, symptomatic of her

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[7] Taylor, *op. cit.*

[8] George Herbert Mead, *Mind, Self and Society* (Chicago: University of Chicago Press, 1934). "The organized community or social group which gives to the individual his unity or self may be called 'the generalized other.' The attitude of the generalized other is the attitude of the whole community. . . . Any thing . . . toward which he acts, or to which he responds, socially, is an element in what for him is the generalized other; by taking the attitudes of which towards himself he becomes conscious of himself as an object or individual, and thus develops a self or personality."

frustration and unhappiness, and by deny-
ing sexual intimacy to her husband. With
this frustration, Mr. J had become more
aggressive and a vicious cycle resulted.

In a separate interview Mr. J had been
encouraged to gain a more objective view
of the marriage.

Caseworker: Can you discuss your mar-
riage in its first weeks and months?

Mr. J: (Detail of his reply is omitted,
but it was an account of considerable hap-
piness and emotional satisfaction.)

Caseworker: You sound as though you
loved your wife then.

Mr. J: I did love my wife . . . (pause)
. . . I *do* love my wife. (Mr. J asserted
this emphatically, as if to convince him-
self.)

(Later, the caseworker held an interview
with Mr. and Mrs. J together. The J's sat
side by side facing the caseworker. Above
detail of early marital happiness was re-
viewed by Mr. J. He repeated that he had
loved his wife, and he knew he still loved
her.)

Mrs. J (to caseworker): That's the first
time he's said he loved me in years.

The skilled caseworker takes advantage
of major "break-throughs" such as this one,
to help the client verbalize his real feelings,
thus reinforcing such feelings and incident-
ally, as in the case of Mr. J, gaining knowl-
edge about himself and his feelings which
may have been temporarily inaccessible to
him. Nothing miraculous may occur from
this, but it can often be an important step
forward to improved interpersonal relations
and emotional health.

HARD-TO-REACH CLIENT

Other examples of applications of role
theory in family casework will come to
mind. But what about the hard-to-reach
client? In some fields of casework, such as
the correctional field, deep-seated disorders
of personality are commonly met among
clientele. There is a frequent suggestion
that casework in authoritarian settings is

different. The current trend which empha-
sizes the generic qualities of professional
practice is a wholesome corrective for some
of our attitudes toward practice in author-
itarian settings. Of course, there are
behavioral sanctions and prohibitions im-
plicit in correctional work. There are the
agencies and agents of law enforcement: the
courts, the judiciary, the police. There
are prisons, reformatories, detention and
remand facilities, and other institutional
restrictions on freedom and self-determina-
tion.

But in the real world of the community
are there not limits too? The total learning
process which we call socialization involves
acquiring awareness of these limits—of the
situations in which behavior is penalized
or rewarded, or perhaps simply tolerated or
ignored, and of the whole system of social
roles in the community. No one is "free"
in the sense of relief from all restrictions on
behavior. The authoritarian setting usually
involves more such restrictions than the
nonauthoritarian setting; but is it not more
a matter of degree, rather than difference
in kind?

Casework and other psychotherapeutic
techniques are not necessarily different
when used with the alcoholic, the sex
deviant, the petty larcenist, or the couple
who are immobilized in their marital rela-
tions. Education in our professional prac-
tice aims at helping the practitioner to get
clues, make evaluations, provide a helping
service for the troubled or ill person, what-
ever the specific problem. This cannot be
overemphasized, for many of us sometimes
feel that the juvenile or adult offender is a
different breed, an inexplicably curious and
exotic problem-person who may be beyond
human help. As is well known, the history
of criminology is replete with theories of
personality which dismiss all hope of change
or improvement in behavior, attributing
crime to heredity, physiology, "somato-
types," "humors," "bad seed," climate, and
other circumstances beyond social correc-
tion. Our new social psychological knowl-

edge enables us to be optimistic about change in human behavior. Even the most derelict of humans may dramatically respond to psychotherapeutic techniques based on newer knowledge.

EGO-DIRECTIVE CASEWORK

Except for the special case of the psychotic, we can assume the client has lived in the same external world in which the caseworker, too, has lived, usually in the same community and locality. He has internalized the social norms of the community, more or less (sometimes less, of course—a type of cultural inadequacy with which social agencies have historically worked). The casework service helps him to be "true to himself," which means to recognize the social norms that have been internalized. Thus the client is helped to come into better congruence with the community. His frames of reference make better "fit" with those of others around him who share the same social world. The client is enabled to integrate his psychic life better with the corresponding psyches of the others in his social world.

Who does this? The client does it, with and through the caseworker. This is neither directive nor nondirective casework. In the conventional usage of these terms, there is a directive aspect in the usual casework situation—namely, the "agent" responsibility of the agency or institution for maintaining community standards and enforcing, directly or indirectly, the community norms. There is a nondirective aspect in the techniques of casework which aim to provide the social atmosphere, the facilitating medium, wherein the client evokes his own sources of help and his own answers from within himself. There is also social control, both in the caseworker's position, in the client's superego, and in the interaction of the casework situation, involving both actual and imputed power. There are values, explicit and implicit, of both caseworker and client, and these are inevitably

influential, whether recognized as such or not.[9]

The term "nondirective" is not an adequate one for the kind of casework we describe. The term "ego-directive" is preferred, meaning simply that the client is encouraged to direct himself from inner wellsprings of knowledge and action. Ego-directive casework is casework aimed at strengthening the ego of the client to the end that he may become self-directing and self-determining—that he may go on "under his own steam." It involves deep respect for personality, and it operates on the implicit assumption that people *do* have internal resources of strength and power.

IDENTIFICATION

We have said that socialization enables the individual to acquire the attitudes and values which predispose him to perform his expected social roles and to secure personal satisfaction in so doing. Through *identification* the individual learns to attribute attitudes and values to others, and thus to anticipate their responses to himself more efficiently. This permits him to guide his own behavior more directly and successfully toward meeting his particular social, physical, psychological, and other needs. Mead referred to this process as "taking the role of the other."[10] Taking the role of the other involves responses which anticipate the responses of others. We are able to communicate with others because we can anticipate their responses through this kind of "role-taking" psychological process.

The deviant individual is one who derives satisfactions in the performance of a role which is not in harmony with his

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[9] *See* Taylor, op. cit., for arguments to support these assertions.

[10] Mead, *op. cit.* See also Nelson N. Foote and Leonard S. Cottrell, Jr., *Identity and Interpersonal Competence: A New Direction in Family Research* (Chicago: University of Chicago Press, 1955), for a discussion of identification as it may be effectively used in casework.

socially expected role. Our casework problem is to devise means for the substitution of acceptable roles for unacceptable ones, and to reinforce these by helping the individual to build an adequate ego structure.

There are two principal conceptual tools in ego-directive casework.

1. *The ego ideal.* Through the use of ego-models the ego may undergo gradual transformation along the lines of socially acceptable standards. An ego-model is a heroic, perhaps more-than-life-size, figure which serves to strike the fancy and capture the imagination of an individual, so that he comes to be caught up in self-imagery, picturing himself as having the attributes of the model. In this process his ego-ideal —his idealized version of self—is modified, including aspects of the ego-model. We emulate heroes. The child who lives in the slum may look up to the gangster; he may try to be brave and dashing as he sees the gangster to be, flouting the authority of the community with impunity. This model becomes incorporated in his ego ideal, so that he comes (in part consciously, in part unconsciously) to pattern himself after the hero, acquiring the values and norms of the hero as he imagines these to be. More prosaic examples might include the ego-models of the "good Christian parent," the faithful, loving wife, the "good-provider" husband, the loyal employee. Famous men and women, such as Jesus, Schweitzer, Lincoln, Bolivar, serve as ego-models for millions of individuals. Ego-models are tremendously persuasive psychological mechanisms for influencing and modifying conceptions of self as these are organized into the ego ideal of the individual.

Casework is concerned in the analysis of ego-models which are presently or potentially influential with the client, or have been operative in the formation of the ego ideal of the client in his past life history. Wherever possible, casework may seek to substitute models which represent socially accepted behavior for those which do not. Ultimately, the goal is to modify the client's ego ideal to include a version of self—an identity—which is in consonance with community norms and standards.

2. *Membership and reference groups.*[11] Groups likewise are potent tools for re-education of the individual. The individual identifies psychologically with groups, which provide him with a sense of belonging, allegiance, and loyalty to something larger than himself. The two strong needs of love and security may both be satisfied by membership in groups such as the family, church, gangs, cliques, and so on. The individual member tends to acquire the norms, standards, values, and attitudes dominant in the group. Many of our clients are identified, through their ego-ideals or through their membership or reference groups, with standards not in congruence with the prevailing standards of the community. In such situations threat to the ego-models, or to the groups with which the client is identified, may be interpreted by the client as threat to himself. Re-education involves the substitution of membership and reference groups which will present the community more realistically to the client, and with which he may identify himself. Once the client has developed new group memberships and has

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[11] Theodore M. Newcomb, *Social Psychology* (New York: Dryden Press, 1950), p. 225. "A membership group is one in which a person is recognized by others as belonging—such as family, political, religious, and social groups. A person shares the norms of his membership groups not only because he is recognized by others as belonging to them but because he has learned to satisfy his motives by making use of shared norms. It often happens, however, that a person also learns to use the norms of groups of which he is not a recognized member. . . . If a person's attitudes are influenced by a set of norms which he assumes he shares with other individuals, those individuals constitute for him a reference group. . . . The significant thing about a reference group is, in fact, that its norms provide frames of reference which actually influence the attitudes and the behavior of a person."

adopted the values of these new groups, a great part of the task of re-education may have been accomplished. Alcoholics Anonymous provides this kind of identification and re-education for the alcoholic, including acceptable ego-models (arrested alcoholics who have successfully coped with their problems) and a group medium through which the ego ideal and group affiliations of the individual may be modified with the psychological support of others. Likewise, the ex-convict who obtains a good job and acquires family responsibilities may be transformed by these new group loyalties and identifications into a law-abiding citizen.

Application of these approaches in casework is basically not different from that in other fields of therapy. They are not even new approaches, for good counselors have been using intuitive knowledge and human relations skills for a very long time to bring about change in client behavior in the manner described. The impressive empirical support for the social-psychological principles involved, deriving from recent researches in human development, is new, however.[12] Today caseworkers can use this information and knowledge more consistently and confidently, with assurance of its efficacy in many of their client's problems.

The concepts of ego ideals and membership and reference groups have been subsumed here under the rubric of identification, and the discussion has been somewhat oversimplified. This was in order to suggest how individual and group influences which have played their part in the behavior of this particular client may be turned around and utilized to change him in the desired directions of change—changes which the client himself (his "true" or "best" self) desires, or through new identification may come to desire.

[12] See A. Paul Hare, *et al.*, *Small Groups* (New York: Alfred A. Knopf, 1958) for a summary of several recent small group researches. See also Gardner Lindzey, ed., *Handbook of Social Psychology, op. cit.*

SUMMARY

Many clients of casework agencies have not acquired, through socialization, social role conceptions congruous with what is socially expected of them. The problem facing the caseworker is how to help the client internalize the proper social norms and acquire an ego structure adequate to support him in performing his roles satisfactorily. Social psychological theory has much help to offer the caseworker in discharging this responsibility. The client may be helped, through identification, to modify his ego ideal to conform more closely to those of individuals who are successfully performing their roles in the community. The change may be facilitated by helping the client substitute ego-models with which he can easily identify. A corollary approach is to help him substitute membership and reference groups, the norms and values of which are in congruence with those of the majority of the community, for those with which he has previously identified. In this manner acceptable behavior is reinforced in the client, psychologically and sociologically, by and through his experiences of social interaction. The new standards are internalized by the client, they become part of him, and he communicates better in his interpersonal relationships because he "sees" the world more as others in the community see it.

It is important that the client be helped to do these things for himself. The goal of casework, in whatever setting, is to enable the client to do and act for himself. If the client's ego-directiveness is enhanced in the casework situation, the modifications in his behavior become permanent and lasting. He is not simply conforming for fear of reprisal or suffering. Casework can help individuals to perform their social roles with ease and spontaneity, with satisfaction to themselves and to others who are in interpersonal interaction with them, and thus to function better in their social world.

BY SIDNEY N. HURWITZ

The Child Who Belongs to Himself

A RECENT BOOK for children tells the story of a delightful shaggy dog who "belonged to himself." As befitted such a unique creature, he went by the unusual name of Crispins Crispian; he lived in his own house, ate strawberries for breakfast, and prided himself on being a Conservative ("one who likes to see each thing in its own place"). Over the months of reading Crispian's story to my young children, I have grown quite fond of him—more so than of the endless chain of "Spots" and "Pals" and "Blackies" and other pets that populate the little children's books greedily consumed in our home. Despite his penchant for strawberries, he is very much a dog (even to the dogwood tree growing outside his bedroom window) and enjoys thoroughly being what he is.

There are children who belong to themselves and to other people; they possess a feeling of wholeness, of uniqueness, of purposefulness. There are other children who are without definable selves, inwardly disordered, without a sense of who or what they are. One finds many children of the latter sort in residential treatment centers. Invariably their backgrounds are highlighted by early and severe trauma growing out of their parents' inability to give wisely, consistently, and adequately of themselves, and out of the chaotic lives to which these parents have subjected them. They

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are children suffering from the emotional cripplers of childhood: deep narcissistic injury, unrelieved pleasure-seeking, deficient impulse control, lack of incorporated parental image, deficient capacities for relating to others, ego disorder, deficient or corrupt superego. They are children for whom life has been primarily a fight for survival, and this survival of their physical being and personality integrity they attempt to maintain by control through their pathology. One finds that they often cannot conceive of mutual survival; rather, it is as if they can exist only through control and ascendancy over adults. Here, then, are children driven by symptoms, with little energy available for constructive mastery—children with little notion that they can or want to be other than what they are at the moment. They lack the feeling of having mastered some orderly growth; they are without clear or satisfying historical references, without a positive concept of their role within their families, their schools, or in relationship to the general community—without clarity in regard to "What was I expected to be?" "What do I want to be?" or "What am I?"

The distorted and undeveloped self-image of these disordered children is covered over by a host of defensive reactions and fantasied or borrowed concepts of self and others (some of which may even be a fixed part of the child's personality). From the ego standpoint, one finds them characteristically handicapped by feelings of very low self-esteem, unworthiness, badness, and inadequacy. Confusions and fears regard-

ing their selfhood are frequently displayed in their great concern over body integrity. They wonder, sometimes in a very literal fashion, whether their limbs will remain attached to their bodies, whether their bodies will remain intact under certain anticipated or real stresses. They are often quite fearful about their physical vulnerability and express undue concern over trivial cuts or pains. They display considerable confusion around their sex. They often have rather fragmented concepts about their feelings, sometimes experiencing a sharp dichotomy between their "good" and "bad" selves, as if they were separately possessed, at different times, by one or the other. They frequently exhibit extraordinary gaps in basic learning (number, time, place, concepts, for example). Often one finds intellectual dysfunction, impairment of thought organization and abstract reasoning power. They tend toward extreme repression of their painful past and/or excessive fantasying and reconstruction of the past in some idealized way.

As residential treatment of children has developed in a variety of settings and under varying professional auspices, it has taken on different forms and philosophies of approach. The institution in which the mode of treatment described below has been formulated is the Edgewood Children's Center, a small (top capacity, 20) child care center catering to preadolescent children who are highly disturbed but without psychosis or organic brain damage. Our frame of professional reference and treatment responsibility is social casework. Psychological and psychiatric consultation is provided to house and casework staff by an analytically oriented psychiatrist and a clinical psychologist. Our children remain in this setting for an average of three years.

When we consider the immense task of restoring, healing, and adding growth to the damaged ego that emerges from such backgrounds, many aspects of the controlled milieu come to mind. We think of the social system of our institutions—of our child care staff, routines, activity structure, plant and equipment, clinical resiliency, etc.[1] And we admit, sometimes with measured reluctance, that we do not have a clear idea of how the various parts of our regulated environments impinge upon the child to effect the changes we see in him. We harbor pet notions about the relative importance of aspects of the milieu; we know something about those aspects upon which we reply most heavily (say, for example, the child care staff); but in evaluating more specifically the many program and interpersonal components as they interact with each other and affect the child, we enter into a realm of speculation where objective assessment and clinical evidence are still quite elusive.

Edgewood Children's Center unfortunately has no definitive answer to the game of environmental juggling. We hope that we juggle intelligently and sensitively, and that there is reasonable consistency within our philosophy of approach. This discussion will deal with the contribution that residential treatment of one prescribed type can make toward the development in the child of new self-concepts. It will attempt to set down what has been most effective in creating an environment beneficial to the restoration of ego bounds and the child's striving toward a concept of selfhood. Admittedly this is an extremely broad area of consideration, touching as it does all aspects of personality structure and their development. There is no psychotherapy without implicit or explicit efforts at some modification of—at the very least—conscious self-perception. The concern here will be with a few of the most fundamental supportive contributions residential treatment programs can provide for the very disorganized child's first strivings toward an effective concept of self. Therefore, this article will focus primarily on the environmental structure as it operates in concert with conven-

[1] Fritz Redl, *The Therapeutic Milieu*. Unpublished paper; presented at the Orthopsychiatric Conference, New York City, March 1958.

tional casework treatment to achieve this goal.

At the point in their experience when children come to Edgewood, they suffer from serious deficiency in their capacities for objective functioning in conceptualized roles, and are driven to inappropriate reactions based on significantly distorted self and external concepts. Residential treatment has as one of its objectives that of enabling the child to relinquish some of his more grossly distorted attitudes and begin reaching out to an ideal of himself that is more satisfying, sustaining, and capable of further maturation.

This becomes the heart of the ego-enhancing and -developing task for which residential treatment programs have unique resources and potentialities. It is a process of energizing the immature and distorted ego so that it eventually opens up to the assimilation of new ways of thinking, feeling, and being.

TREATMENT TENURE

A basic concept of the Edgewood program is the conscious awareness and use of the length of treatment stay. As noted above, this is estimated at three years, a practical evaluation based on experience with the rate of progress the children are ordinarily capable of achieving. This three-year estimate is shared with parents and child; a family incapable of accepting such a prolonged separation is asked to withdraw its application. Granting that the time estimate is hardly infallible, we see considerable value in its acceptance by the client. In return for the family's and the child's investment of time and energy, we are lending assurance of our own prolonged investment, which will not be withdrawn except under extraordinary circumstances. Children who have suffered the astounding number of changes of residence, town, and school to which our children have been subjected —more in their young lives than many an adult undergoes in his entire lifetime—require stability of place as an absolute minimum for their security.

Relatively lengthy treatment tenure takes on various meanings for the highly disturbed child at various points in his treatment. After the initial anxiety over placement begins to subside and he begins to realize that his placement is more than a transient experience, he will usually ask, "When do I get to go home?" From his first awareness that something basic has happened in his life to the day of discharge, *time* is used as a purposeful tool in the child's treatment. He is gradually helped to become aware of the relationship between time and his individual growth, not merely physically, but emotionally and socially. Time may be used as something of a frame of reference, particularly for the older child. In effect we may say to him, "You will go home when you are ready to master certain of your problems, and we think you may be ready to do so after such-and-such a period of time." As a child adapts to the institution, becomes more dependent upon it and identifies with it, he often grows quite concerned because the passage of time is speeding his discharge. By now the child is better able to handle anxiety, and we can afford to make conscious use of the push of time to stimulate concern for the reality of his future and his need to prepare for certain adjustments. For the child who is finally ready for discharge, but fearful and resentful about separation from us, time may be used now as an impersonal element dictating action both for him and for the institution.

A CURATIVE EMPHASIS

A concept of time has no meaning without a correlated concept of treatment and growth; hence, *time* is for *getting well*. It is our intent with the children and their families always to handle the actuality of the child's disturbance in as honest a fashion as is possible or sensible. Our implicit and explicit emphasis throughout the program

is on the institution as a curative atmosphere; aspects of program are accordingly described to the child as facilitating his progress toward problem-solving. Hence, for example, we tell our children that they are required to attend casework interviews because they will thereby gain help in overcoming their problems. This rather formalized emphasis on their illness and its alleviation seems to us quite in keeping with reality as we see it and as the child himself sees it. This is not to suggest that all, or even a majority, of our children have some conscious awareness of their illness or specific realization of what their problems are or what they want to do about them. There are children who actually seem to grasp why they are in placement and seem to want to utilize the environment in a treatment-directed way; others have little realistic understanding of why they are in the institution or what, concretely, is wrong with them. However, all our children suffer a kind of fixed sense of failure and of hopelessness about them. To the degree that our environment begins to suggest our reparative and restorative function—our confident expectancy and optimism as to their potential for change (and eventual success) —to this degree they may be able to open themselves to the possibility of change.

The emphasis here is primarily on the desirability of the child's experimenting with new approaches to life situations. There are many formal and informal opportunities when he can be helped to a somewhat more objective self-evaluation and evaluation of the environment. Ordinarily the child is drawn into planning around our periodic conference reviews of his progress. He will be asked how he evaluates his use of program and people, and what problems he feels remain to be worked on. Conference findings, to the extent that he can comprehend them, will be shared with him. He will frequently discuss these findings further with his house-parent, who has participated in the review. Of course, such discussions with the child will emphasize

heavily any realistic positives in his adjustment.

The administrative intention of a "curative atmosphere" is no less important for the child care staff, who may otherwise lose perspective and drift into a nonclinical, superficial custodial role with their charges. We hope, on the other hand, to avoid an atmosphere of clinical anxiety of the kind that engenders get-well-quick pressures, which are inappropriate and intolerable to the child. There is a fine line to be drawn here between "You must get well" and "We believe that you can get well."

Most of our conclusions in this area must be drawn empirically. Gradually, our children begin to compare their behavior with that of other children in a more realistic manner. Slowly they begin to relate their present to their past behavior, with great satisfaction in currently greater mastery. There is a growing kind of future-mindedness, a beginning awareness of self as an active agent in effecting positive change. These manifestations of greater objectivity undoubtedly stem from a wide variety of stimuli impinging on the child; the consciously expressed attitude here described gives, we feel, additional impetus and direction to the process.

EXTERNAL BOUNDARIES

Fundamental to the development of self-identity is the capacity to separate "self" from "nonself." [2] At the core of the residential treatment child's illness is his previous failure to achieve adequate performance of this task. One sees it most dramatically in that group of hyperactive, primitive children—mostly boys—who appear to be under persistent pressure to stir up some kind of intensive interaction between themselves and the outside world. They are subject to emotional flooding by the weakness of their impulse controls and

[2] Beatrice R. Simcox and Irving Kaufman, M.D., "Treatment of Character Disorders in Parents of Delinquents," *Social Casework*, Vol. 37, No. 8 (October 1956), p. 289.

are seriously deficient in ability to distinguish between various types of tension. They share—along with other children who attack the environment less aggressively—deep distrust of interaction with adults and deep fear and rejection of adult control. The need for nearly all our children is to control, corrupt, distort, or evade adult expectations. At the least, they are always suspicious of being exploited; at the most, utterly annihilated by adult encroachment. With many of them the only "effective" control they have ever wielded over their environment has been through their symptoms, by means of which they have managed to achieve the attention, the degree of adult anxiety and vacillation, the bribery, relaxation of expectations, or whatever compensatory satisfactions they have sought. One sees related to their illness the high degree of megalomania they incorporate into it, the persistence with which it must be maintained, and the terribly distorted attitude toward child-adult relationships involved.

The job of diminishing our children's need for pathological distortion and increasing their willingness to take in more objective perceptions is, we feel, greatly facilitated by our use of limit-setting. It is particularly difficult to convey adequately what an institution practices in regard to establishing and maintaining rules and procedures of life. Even descriptions of specific regulations and their application ring hollow without careful evaluation of the total framework in which these operate, including the personalities of those responsible for maintaining the procedures. Again, in such a description one is hampered in attempting to communicate through words like "firmness" or "lenience" by their varying connotations for different practitioners. All that is intended here is a brief consideration of the significance of external controls and their possible contribution to the therapeutic atmosphere.

From the treatment standpoint, institutional authority (cottage rules and procedures) plays a vital role in reducing individual and group anxiety by enabling the children to achieve mastery of many life situations, and by reducing infantile megalomania and helping children to accept the adult in a protective, supportive role. Reduction of anxiety comes about partly from the child's being able to rely on great consistency within his institutional world. We would have him depend as heavily and surely on our control over his destructiveness as on our wish to love and give to him. We strive to formulate for ourselves and the children as specific and internally consistent a moral and behavioral code as is possible among an aggregate of adults of diverse backgrounds and motivations, and to implement this code scrupulously. It has become highly apparent to us that child management which announces its expectations with definiteness and sureness, which acts swiftly to curb significant violations, and which employs penalties and rewards with equal appropriateness, ease, and skill greatly reduces anxieties. Child handling that is vacillating and insecure or too permissive produces the greatest anxiety in our setting.

Although daily procedures are not ends in themselves and should not be overevaluated as such, the ability to fulfill schedule and task requirements is a most desirable objective for the child. Getting to school on time, eating one's meal properly, dressing oneself—these can all be sources of tremendous satisfaction to him. With the fulfillment of these routines comes a feeling of internal control which reduces the child's sense of helplessness and fear of being overwhelmed by the outer world. The highly disturbed child is often much more capable of accepting the adult as a protector than as a trustworthy source of satisfaction. He welcomes the protection of adult control against the potential of his own overwhelming feelings, and for the implicit association this bears of protection against the adult's potential rage or retaliative wishes. We believe that the predictable

and safe environment, where the child knows at all times what is expected of him and what will be tolerated of him, is best suited for the reduction of primitive and conflict anxiety. Energies formerly drained off in pathological ways to maintain the weak ego bounds, but now supported by a strong external environment, can be directed in ways that will contribute to genuine ego mastery and growth.

In an institution, to a degree unlike the home, the same rules are reiterated by different people over and over, not merely to the individual child but to the group as well. The relative impersonality of this process reduces for the child the sting of adult "me-against-you" authority. Under these circumstances, transference of anger or fear from earlier adult figures to present environment is more easily dealt with; the child can more readily be helped to separate "self" from "nonself."

MATERIAL PROVISIONS

The disturbed child reveals his feeling of low self-esteem in much of what he says, what he does, how he appears, his choice and treatment of possessions. These signs poignantly reveal his sense of damage and worthlessness. Some children display their feeling of inner shabbiness literally on their sleeves; they cling to dilapidated clothing and appear always dirty and ill-kempt despite all our efforts to improve their grooming. Others, by the way they dress and move about, appear to be falling apart—as indeed they feel inwardly. Although most of them seem to place inordinate value on objects that come into their possession, some persistently seek and cling to only the most worthless objects: scraps of wood or metal, fragments of pictures, old cans and bottles. They tend to destroy their own creations when they first come into residency, as if to say that nothing good can possibly emanate from themselves. Initially their sense of impending failure is reflected in their approach to any new task. Verbal

expressions of inadequacy (some of the children capitalizing heavily on this in a deliberate, self-pitying manner) are commonplace.

The physical environment of an institution and the use child care staff makes of physical supplies can do a great deal to improve the child's self-image. In effect the environment should convey to the child belief in his wholeness and worth-whileness. Some of the implications of this are obvious: cottage and grounds should be maintained in good order—clean, and in good repair; the children's possessions should be similarly maintained to the extent they will allow us to do so, and every effort should be made to help them keep their persons clean and well groomed. This calls for child-centered (but not child-dominated) housekeeping. We appeal to the image the child would like to have of himself. We make persistent, articulated efforts to convey to the youngster that what we are providing is wholesome, intact, nourishing. We attempt to wean him from his self-depreciatory behavior, offering in its place ego-enhancing materials. The child who grabs food scraps from the floor is not admonished for poor manners, but for choosing undesirable food rather than desirable food. The child who persists in clothing himself with ragged articles of wear may be given some leeway in holding on to what is familiar and comforting, while we urge him to try new and more attractive garments that others will admire. We attempt to prevent the children's destruction of their own creations, not merely because we dislike destructiveness, but because we see value in what they have created. In this area everyday cottage life provides endless opportunity for staff to help the child slowly take on the concept we hold of his innate worth.

In this connection one thinks immediately of food given to the children—its preparation, serving, and staff attitude toward it. Food is the most immediate and persistent point of "taking in" to which the child is

subjected. Ten-year-old Billy's constant question during his first months at Edgewood was "What did you eat for lunch?" Billy was phobically concerned about his environment; he saw it as all "cootied up." What he required was a food "taster," someone to judge for him the degree of contamination of his surroundings. We cite his attitude because it points up the importance of the feeding process—a process both literally and symbolically never before adequately gratifying to the emotionally deprived child.

ROLE CLARIFICATION

The seriously disturbed child has not had the opportunity to establish concepts of himself, in relation to parental and general community standards, appropriate to his age and capacities. We find him characteristically vacillating between competition with the adult, usurpation of the adult role, and infantile behavior and dependency. Frequently these children have developed a façade of pseudomaturity and independence well out of line with their chronological age. As noted earlier, sexual ambivalence and confusion are often encountered. The child, of course, attempts to involve child care staff in perpetuating for him the position he needs to maintain. Ordinarily these are efforts to reconstruct to some degree what the child felt and experienced in his own home, and the methods by which he coped with it. Consequently, we are forced initially into demonstrating for him that this environment is a separate one and different from the one from which he comes, and that it cannot be converted into a new battleground constructed along the lines of the old battleground. Eleven-year-old Lynn illustrates some of the process that goes into new role formation.

Lynn has been with us over a year. The description she earned from the onset of placement—"junior house-parent" —still applies, but to a more limited extent. A narcissistically fixated child, she attempted to derive her satisfactions from constantly being in the limelight. She had little confidence that adults or peers would provide her with adequate emotional supplies, which she persistently sought through intruding upon others, sometimes in a rather arrogant, officious way and sometimes with considerable poise and skill. The child's need to control, to be given constant approval and attention, to win favor through doing services, to compete with and depreciate adult services, to deny her own dependency needs, was quite blatant. The intensity of these needs soon alienated the other children, who deeply resented her arrogance and pseudomature affectations.

Helping Lynn to greater trust of adults and acknowledgment of some of her deep dependency wishes has been a process of intelligent and lengthy collaborative effort between institutional cottage and casework staff. Part of this effort has aimed at clarifying for the child the role in which she operates and demonstrating to her what we consider a more suitable and potentially gratifying role. From the house-parent's standpoint this involves a conscious, structured teaching process. Lynn's "junior house-parenting" was repeatedly pointed out to her for what it was, with emphasis on her trying instead to allow the adults to care for her as well as for the other children. She was confronted, at appropriate times, with the effect her bossiness had on her relationship to other children. House-parents demonstrated that they wanted to cater to the natural dependency her youth demanded, and to some of her more infantile wishes so far as these did not involve undue regression. In countless situations she was given direction to modify her controlling and obsequious behavior and direct it into channels that brought her more genuine approval and constructive recognition. Lynn began to refer to herself in a questioning and critical way; she applied the "junior house-parent" label to herself and consciously began to limit this tendency.

We evaluate this kind of purposeful direction as the conscious, teaching facet of treatment. It does not attempt to deal directly with the unconscious motivation creating the problem, but gives the child an intellectual awareness of behavior and personal interaction as well as new methods of handling live situations that can be the forerunners to incorporating different attitudes about himself and his environment. Deliberate role-structuring efforts have little meaning for the child unless carefully thought out in relation to his personality structure and current needs. They cannot be mechanical impositions, as false and ineffectual as roles the child has previously adopted for himself. After a year of treatment Lynn remains a long way from having enough trust to depend upon adult support or approval, but she is developing rather conscious approaches to people which she finds much more gratifying than her previous efforts.

THE PURSUIT OF MASTERY

Implied in this description of the disturbed child is the large number of such children suffering from chronic failure of adequate mastery over instinctual wishes. In instances where the child has developed excessive repressive defenses, so much ego energy must be channeled into maintaining the repressive forces that little remains to be directed to emotional growth. In either event the end result is deplorable impoverishment. This is reflected in every area: the toll is apparent in intellectual dysfunction, lack of creativity and spontaneity, limited mastery of skills, and so on. The emotionally disturbed child is so involved in his pathology that he has not developed effective capacity to take in what normal children absorb naturally and hungrily. He knows his inadequacies, or at least *feels* them deeply; contact with more normal children accentuates for him his inability to compete successfully.

Paul, a newly placed child, expressed well his ambivalent feelings about coming to the institution. He said, "This is a crazy place but it looks like I do things better here." He reflects his concern about the behavior of the other children, but he also feels in our setting a degree of freedom from the pressures to compete which he experienced in his own home and school, and he senses our comfortableness in accepting the best of what he can do without too much emphasis on what he cannot perform.

Mastery begins with the child himself— what is he capable of performing? What does he want to master? How much anxiety, and what kind, underscores his dissatisfaction with his present adjustment? How has he mastered previous situations and task or relationship problems? Essentially we ask ourselves: what does mastery mean to this child? We recognize its often frightening potentialities. Growth and accomplishment may mean to him imminent exposure to further adult expectations—abandonment of certain comforting attitudes ("I can't do this, so what's the use of trying"), the loss of a certain infantile position that has been associated with other gains. In time the child shows us his needs if we are alert to what he does and how he does it. For example, the narcissistic, pleasure-driven child tends to be impulsive in his tasks, seeking quick gratification from whatever he tries to make or do. He cannot tolerate the tension of painstaking effort, and the results of his endeavors plainly show this. Such children have to be helped to put on the brakes of their impulse-powered persons. They have to be restricted to the use of implements and media that require little subtlety of handling; they have to be emotionally primed or momentarily distracted at the point of effort where excessive disorganization sets in. At times the adult in charge may have to step in and finish a product or task in order to preserve the constructive achievement that the child cannot carry to completion.

The drawing of a picture or completion of a homework assignment, say, is not an

end in itself. We would like our children to associate their productions with themselves and to value their productions as they grow out of their own capabilities. If Susan copies Sally's picture and brings it to the housemother for praise, the adult may respond that Susan has copied well, but "I like best of all things that just come from Susan." The child himself often sees no value in his own productions. He does not belong to himself sufficiently to know his own desires or have any sense of his own powers of creation. It is our task to convey to him his potential; to control the speed and direction of his efforts so as to involve his maximum investment, concentration, and perseverance in areas of accomplishment attainable at any one point in his development. In this process we anticipate dealing with rather infantile competitive attitudes, abject despair over failure, disavowal of interest in new (and usually feared) learning or doing, easy distractability.

The illustration here has been primarily of skill mastery rather than other areas of mastery, for several reasons. First, this area of deficiency is so universally applicable to our children. Second, remedial efforts in this area often provide a ready entree to the child who is not yet ready to take from us on a deeper level. Third, it involves endless possibilities for tangible proof to the child of his innate capability. Space will not permit further elaboration of this broad and interesting area, which has so many applications for highly imaginative and flexible teaching methods as well as emotionally corrective measures.

EXPERIMENTAL LEEWAY

Sometimes it has been said that institutions allow more symptom tolerance and accept more unconventional behavior than would an ordinary home or foster home. This cliché has only limited validity. It assumes that the child is the *same* child in the institution as at home; but he is not. It

assumes that child care staff (ever loving, patient, and sensible as we hope they will be) can legitimately tolerate any and all deviations of conduct. Even if they could go along with seriously deviant behavior in an individual it is clear that to allow such behavior to continue might be highly demoralizing for the total group of children. There are, in fact, certain types of deviant behavior theoretically much more tolerable in a private home than in an institution, where one is constantly concerned for the effect of such behavior on others. Providing experimental leeway for the institutional child in his tortuous steps toward growth is a vital necessity, but by no means a simple matter. To illustrate: 9-year-old Margie recently began punching her housemothers as they passed her. She did this with malicious, obvious pleasure and often accompanied the blow with cries of "I love you!" Her most telling blows were kept for her favorite housemother. She was just emerging from being a fearful, isolated youngster and had apparently developed sufficient trust in new parent figures to be able to display openly her ambivalent feelings toward the mother person. In this instance Margie is rather obviously trying on some new behavior "for size." She had never dared express open resentment to her own mother. The release she felt in this new behavior was quite exhilarating. Because it was such an obvious step in her growth toward relationships we were not alarmed; as expected, her punching phase was a transient one.

Decisions about handling such problems are constant in an institution. Our criteria in regard to each instance attempt to take into account its meaning for the child, how it fits into past history and current growth efforts, its effect upon the group, and our own attitudes toward the behavior and capacity to accept it. The intelligent application of these criteria differentiates leeway from license. At times one feels that the peer group itself intuitively distinguishes adult flexibility from adult in-

difference, laxity, or playing into a child's manipulations. If the child care staff is reasonably aware and in control of the degree and kind of flexibility it allows a child, this sense of purpose can usually be transmitted to the group and be constructively accepted. In effect we hope to convey to the child that, within certain bounds, it is all right to experiment with various solutions as a way of learning how one can operate most constructively and effectively.

SUMMARY

The structures and general techniques discussed here are meant as guideposts for child care staff in their efforts to relate to the disturbed child. Relating to such children is a difficult and prolonged experience in communication of thought and feeling. The successful handling of the various treatment problems, as here emphasized, is naturally predicated on the quality of our quasi-parental (house-parent and the like) and therapeutic (casework) relationships with the child. How these are formed, how they progress, and the uses that can be made of them on a more individualized basis are complex considerations not within the scope of this paper. We do believe that the groundwork for initial compliance to adult expectations, as well as for later identifications and for eventual integration into the child's own personality of institutional and individual adult standards and attitudes, is laid in our early approach to ego management and enhancement.

BY B. ROBERT BERG

Combining Group and Casework Treatment in a Camp Setting

THIS PAPER DESCRIBES an experiment in combining group and casework treatment in a camp setting with one professional person serving both therapeutic roles. There is already considerable literature which demonstrates that the camp setting can be used therapeutically and as a planned resource in the treatment of emotionally disturbed children.[1] Many social agencies now use the "treatment" camp as an integrated part of their total treatment plan for a child and his family. Through the use of reports and conferences back and forth, the camp experience becomes a kind of collaborative treatment situation. Jackson and Grotjahn have listed some of the advantages in the combination of group and individual therapy. They also cite other authors who believe that by integrating group and individual therapy "treatment is accelerated and deepened." [2] Wilfred C. Hulse found that patients treated by combined therapy developed a more intense transference than if just treated intensively in individual sessions.[3]

For administrative reasons, the Jewish Family Children's Service of Minneapolis had been unable to establish treatment groups for children even when the diagnosis clearly indicated them as a desirable treatment resource; no such facilities exist in Minneapolis. Therefore, in an effort to fill this gap for some of its case load, the agency decided to offer an intensive brief experience at a resident summer camp, where the values of therapeutic group living could be offered to a selected group of boys already receiving individual casework treatment. The camp was operated by the Emanuel Cohen Center, a professional group work agency serving all socioeconomic levels of the Minnesota Jewish community. It was coeducational, offered three three-week periods, with about 96 children in attendance at any one time. The Children's Service paid their worker his regular salary plus travel expenses. The camp provided another counselor and paid his salary, as they

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[1] *See,* for example, the extensive bibliography which follows Elton B. McNeil's article, "The Background of Therapeutic Camping," in the *Journal of Social Issues,* Vol. 13, No. 1 (1957).

[2] James Jackson, M.D., and Martin Grotjahn, M.D., "The Treatment of Oral Defenses by Combined Individual and Group Therapy," *International Journal of Group Psychotherapy,* Vol. 8, No. 4 (October 1958), pp. 373–382.

[3] Wilfred C. Hulse, M.D., "Transference, Catharsis, Insight and Reality Testing During Concomitant Individual and Group Psychotherapy," *International Journal of Group Psychotherapy,* Vol. 5, No. 1 (January 1955), pp. 45–53.

would for any group.[4] The camp was not set up to meet more than the usual needs of typical summer campers; in other words, it was not a treatment camp. However, its program was established on sound group work and mental hygiene principles and the modification necessary for this treatment group was minimal.[5]

Therefore, it seemed likely that the agency was on sound ground in providing a therapeutic group experience in a camp setting for a select case load. In the wish to add another dimension to the treatment possibilities, it was postulated that if the social worker who worked with the boys in their individual session also lived with them as their worker and parent figure, the intensive relationship that might result could possibly accelerate movement. Of course, there were dangers: there was the chance that the worker's authoritative role *in loco parentis* might adversely affect the individual treatment relationship, which is usually thought of as more permissive in nature. Rivalries and competition for the worker might create problems by intensifying negative feelings. But it was felt that the potential benefits sufficiently outweighed the potential dangers to justify the experiment. An attempt to minimize rivalry could be made in preparing the group (see page 58).

EXPERIMENT AND SETTING

A group of ten boys, aged 8 to 12, all of whom had been seen individually by the social worker for periods ranging from three months to three years, lived together with him at a summer camp for three weeks.

[4] The camp fee was $120 for the three-week period. Seven of the families were able to pay the full fee, and the other three families paid an adjusted fee figured on the sliding fee scale used by the camp for all families unable to pay the full fee. In other words, the project did not cost the camp more than any of its regular groups, and cost the Children's Service only travel expenses and the loss of services of one of its workers for three weeks.

[5] The camp follows the philosophy expressed in the author's *Psychology in Children's Camping* (New York: Vantage Press, 1958).

The boys had been selected from a group of twenty and were chosen with an eye to forming a balanced group in terms of behavior and personality characteristics. Factors which ruled out inclusion in the group were: (1) too extreme and deviant behavior; (2) too low intellectual level; (3) too little maturity for a living experience away from home, and (4) any characteristic that would overbalance the group too far in one direction or another, *e.g.,* too many passive or overaggressive individuals.

The group lived together in a cabin consisting of two rooms and a porch. In the large room were four double-decker bunks and two single cots. This is where the ten boys slept. The smaller room was occupied by the therapist and an experienced counselor who also worked full time with the group. Both adults worked with the group at the same time, except on occasions like days off when each handled it alone. While the boys tacitly understood that the social worker had primary responsibility for them, the very close and positive working relationship between the worker and the counselor prevented any real problems of divided authority, inconsistency, or playing of one adult against the other.

There has been little in the literature concerning camp operation of both treatment and "normal" cabin groups simultaneously.[6] Perhaps this is because of understandable questions as to whether one might interfere with the other. Our experience was that, despite the very considerable individual problems of some members of the treatment group, the unit as a whole was easily integrated into the total camp program. The group functioned as any other cabin group in relation to the rest of the camp. Its essential differences were internal (in the use of the group process in a planned therapeutic manner) and not ap-

[6] Perry Roth, *An Evaluative Study of a Therapeutic Camping Experience for a Group of Ten Boys.* Unpublished master's thesis, University of Minnesota, 1959.

parent to the other campers. This is illustrated in what follows.

PREPARATION OF THE GROUP

A number of individual sessions were spent with each child preparing him for the camp experience. In addition to a general orientation to camp and group living, special emphasis was placed on the group as a device to further the child's individual treatment. The parents also had individual sessions about camp. There was at least one joint meeting with parent and child together in which specific treatment objectives were formulated which were acceptable to everyone concerned. In some of these joint meetings the parent's worker and the child's worker were both present; in several, only the child's worker was there.

There was one precamp group meeting which six of the ten boys attended. Efforts were also made to have some of the boys get acquainted before leaving for camp so as to minimize the strangeness and aloneness. As part of the preparation and in an effort to lessen rivalry, the worker discussed at some length with each child the fact that he would now have to share the worker with others rather than have him all to himself as in the individual sessions. With the help of the consulting psychiatrist, a number of techniques were developed such as the one just mentioned, which tend to inhibit the expression of rivalry in these boys. They consist of both verbal and nonverbal ways of indicating to a child that rivalrous behavior is not acceptable. Space does not permit detailing this further. We wanted to control this for two reasons: (1) it could present serious problems in the management of the group, and more important, (2) in the short camping period we did not feel we could successfully work on this problem area without sacrificing the work that could be achieved in other areas. Since we had specific treatment goals for each child, we did not want anything to interfere with focusing on them.

PROGRAM AND THERAPY

The camp offered a wide variety of camping and athletic activities. Each day the children had an opportunity to use these facilities as individuals and as groups. In the morning there were two activity periods. In one the cabin group evolved its own program. It might, for example, go on a hike, work on a project, or engage in some sports activity. The other period was known as a special interest group. As individuals, the campers picked one of a variety of special activities and left their own group to join members of other groups in this special activity. In the afternoon one period was devoted to swimming and the other to an activity selected by the cabin group. In the evening there was a long free play period, when the child could do anything or nothing, with or without his own group or with the other campers—followed usually by an all-camp or all-unit program (the camp was administratively divided into two units). Each cabin participated equally in the program of these over-all camp activities.

Therapeutic forces and techniques operating in this setting included the following:

Primarily environmental or group forces

1. Reality testing. The child learns whether his fears and assumptions hold up in the living situation.

2. Control of behavior and impulses through group pressure (approval or disapproval).

3. Release of crippling inhibitions as a result of the noncritical attitude of the group to poor performance in areas of skill.

4. Release of inhibitions as a result of group support and encouragement.

5. Ability to face problems because of their universal nature. In other words, the knowledge that everyone in the group is there for help with problems creates an atmosphere of mutual acceptance and understanding which is conducive to tackling the problems.

6. Opportunities for acceptance and status and success.

7. Identification with healthy elements of other group members.

Direct involvement of the worker

1. Individual discussion and/or interpretation to the child of behavior.

2. Direct individual support or encouragement to the child.

3. Support and encouragement to entire group.

4. Group discussions of incidents, problems, each other's behavior.

5. Mechanical manipulation of environment—switching positions of beds or places at the table, arranging special treats or privileges.

6. Control techniques—the variety of methods, including physical intervention, visual and auditory cues (ways of telling the child by means of signs or words to stop what he is doing), and all the time-honored disciplinary tools.

CASE ILLUSTRATIONS

The following four brief glimpses demonstrate that what was accomplished in each incident depended on both the camp setting and the presence of the child's own worker.

Harold, the oldest boy in the group, was observed early in the day talking two of the boys out of a fight. Generally passive and withdrawn, in this smoothing-over activity he seemed quite consistent with what we knew of his personality. Later on the same day, however, he was overheard urging an aggressive boy to beat up a more inadequate youngster. The worker discussed these two observations with Harold alone shortly afterward. The youngster's response revealed that for some time he had been having an active fantasy life around torturing and being tortured and was in much conflict because of it. He feared he might be crazy.

In the year of treatment preceding camp Harold had been unable to bring out any material relating to his conflict in this area.

Through our observations at camp, and the worker's opportunity to follow it up immediately, we were able to be of considerable help to Harold.

Morton, age 9, lived alone with his widowed mother. They had a most unhealthy relationship, one characteristic of which was the control exercised by the boy's refusal to eat and by his use of illness. Interpretation during individual therapy sessions of the meaning of his behavior had received intellectual acceptance only.

At camp, not having to cope with a parent figure like his mother, Morton presented no eating problem. However, there were opportunities to handle some of his other control techniques by meaningful on-the-spot interpretation. At one meal, for instance, Morton was quite obstreperous and had to be told firmly by the worker to quiet down. A few minutes later he complained of a headache and asked if he could return to the cabin without completing the meal. This was permitted, and the worker joined him immediately after his return to the cabin. At this point the cause of Morton's sudden headache was identified as related to the worker's having corrected his behavior (as his critical mother did). Morton's headache was interpreted to him as the kind of retaliatory control device used by him with his mother. The headache immediately disappeared and the youngster returned to the group.

Through the opportunity to make the interpretation at the time of the behavior we were able to help Morton achieve emotional insight—something we had not been able to do in individual sessions.

Jerome, an 11-year-old boy, had been in America for only two years. In Europe he had experienced extreme physical and emotional deprivation. He was a youngster with very weak impulse controls. His need for immediate gratification and his inability to stop or give up a gratifying activity presented difficult behavior problems of a delinquent nature. It seemed clear that this child needed not insight therapy but an

entirely different kind of handling and corrective emotional experiences. Because the parents were also extremely deprived emotionally, they were limited in their ability to modify their handling and change their attitudes in the way this boy needed. Weekly casework interviews for parents and child had proved insufficient in and of themselves to help this boy achieve controls. His delinquent behavior had brought him to the attention of the Juvenile Court and made placement in a correctional institution seem inevitable.

The camp experience provided an opportunity to test the theory that this boy could change and acquire controls in response to a definite kind of handling and a more positive set of attitudes. The new approach involved very firm controls, non-punitively applied and concurrent with great efforts at providing gratification. As an example, we have the handling of eating at the table. Jerome ate vast quantities of food, and it was possible for each child to have as much as he wanted. However, before giving second portions, the kitchen had to serve "firsts" for some 140 people. Consequently, each child could have only a reasonable first portion if everyone was to be served at approximately the same time. When the platter came to Jerome, he could not believe at first that he would really get all he wanted during the course of the meal. He tended to take so much immediately that half the boys had to wait until seconds were available before getting their firsts. Speaking to Jerome about controlling his initial portions did not help. He did not have the ability or the trust to count on seconds and to limit himself temporarily in anticipation of more. This had to be handled by having the worker serve him. Although he was the only boy not serving himself, there was no punishment involved. The worker served him an ample first portion, without anger or negative comments, merely observing that we realized Jerome could not control himself in this area yet and that we would help him

with this until he could do so by himself. In addition, the worker went out of his way to make sure that Jerome always had all the seconds, thirds, and more of the food that he wanted, so that the attitude of wanting to gratify him and meet his needs was always apparent.

In response to the nonpunitive, very firm controls and all-out effort to gratify his needs, Jerome made dramatic progress in three short weeks. Not only did he show improvement in self-control but he even showed beginning signs of incorporating controls. The response to the therapeutic camp experience was so positive that the Juvenile Court was convinced that he could be helped through treatment. Instead of sending him to a correctional institution, the court allowed the agency to place him in a foster home using the approach described above. It seems likely now that this boy can be helped to a healthy adjustment. An important factor in the court's decision to allow the agency to continue its treatment plan—despite pressure from the community to "put him away"—was the boy's response to the camp experience.

Jeff, age 10, was a fearful, passive youngster who avoided all group experiences. He felt generally inadequate and avoided swimming and baseball and most organized games and sports. He was reluctant to attend camp and was able to bring himself to do so only because his worker would be living with him. In response to the group atmosphere, and with the direct support and encouragement of his worker, Jeff was able to develop skill and derive real satisfaction from baseball and swimming. His behavior became more outgoing and aggressive. His favorite comment during the first ten days, "I'm afraid," was no longer heard in the second half of the session. In truth, this boy was no longer inhibited by fear.

It is our impression that the rapid movement in these areas resulted from the effective combination of a therapeutic group living experience for the child with the individual relationship with his worker.

RESULTS AND EVALUATION

A committee has been meeting in an effort to evaluate the results of this experiment in terms of its helpfulness as a treatment tool.[7] We also hope to compare the adjustment of these boys at the point they first started casework contact, as they were at the start of camp, as they were directly after camp, and then to follow up at various points during the next year or more. Every boy except one continues in active contact with the agency. Our efforts to obtain a comprehensive picture of the boys directly before and after camp will be considerably aided by some research in progress connected with this experiment.

To the agency the camp placement was of value in the case of each boy. Even in those situations where progress was limited or not seen, there was an opportunity for better diagnostic understanding which in itself led to a better treatment focus and consequently greater progress in treatment. In four instances there was dramatic movement in a positive direction. Three of the boys whose behavior was inhibited, fearful, or generally passive and submissive showed considerable progress in the direction of more outgoing, uninhibited, less fearful behavior. The fourth case was equally dramatic and showed marked progress toward establishing behavior controls.

In four other cases there seemed to be clear-cut but more moderate progress in areas selected before camp as the ones to focus on. The term "moderate" is used only in connection with the four cases mentioned above. By comparison with actual progress in each case up to the time of camp the movement was quite considerable in several instances.

[7] The committee consists of B. Robert Berg, the worker; Edward Berkowitz, family department supervisor; Dr. Gove Hambidge, consulting psychiatrist; Morton Perlmutter, caseworker; Callman Rawley, executive director; and Perry Roth, camp director. The committee members commented on this paper and their suggestions are incorporated in this version.

One case was apparently a complete failure—a boy who had been making some progress in establishing controls over his behavior regressed to a position of virtual uncontrollability. The youngster had been under terrific pressure in successfully controlling himself in school. The controls were not really internalized, and he had, in a sense, used himself up in that effort and did not have the psychic energy left at the moment to invest in further self-control. The seductive, stimulating, wide-open camp atmosphere was too overwhelming for such an infantile control system. It was necessary to send him home after completing only two-thirds of the session. The last case, an 8-year-old, showed considerable progress during the first two weeks and a marked regression (to below the level first demonstrated at camp) during the final week. This boy apparently could not cope with the large three-week dose. His prescription should have been for two weeks, which was all he could tolerate at this point of his development. This raised the question of how much time each child could tolerate in such an intensive treatment situation away from home. For some, undoubtedly, more time might be helpful, while for others less would be necessary.

The over-all impression, however, is that there was considerable movement in terms of behavior changes during the three-week session. Furthermore, in a majority of the cases progress seemed quicker than had been observed in the course of treating the family and child through weekly interviews.

SOME IMPORTANT QUESTIONS

In planning for the next year and deciding whether to repeat the experiment along similar lines, one important question arises. It was demonstrated that the method is a successful treatment tool worth further exploration; the question is whether the same gains might not be made just as well by using the camp and a trained group worker and not having the individual worker fill both roles.

One way of answering this, of course, is to run two similar groups, one with and one without the individual worker, and try to see whether there is any appreciable difference in movement between them. Such an experiment would be interesting, but subject to many variables and consequent distortions. For example, it would be difficult to equate the two sets of boys accurately in terms of depth of disturbance. Similarly, it would be hard to equate the two therapists in terms of professional skill and personality characteristics. The two groups would probably be alike mainly in superficial characteristics of the children, such as age, I.Q., and gross type of problem.

At this point, we have tried to answer the question by a process of speculation based on our knowledge of certain dynamic factors. Much of the following thinking was advanced by the psychiatric consultant. It was definitely felt that using the same person for both individual and camp therapy was a greater aid to treatment than using different workers in each area, for these reasons:

1. Because the camp period is only three weeks long, the already existing one-to-one relationship between therapist and child is important. It enables the child to avail himself more quickly of the group without using up valuable time and energy working out his adjustment to the key adult.

2. The emotional investment the child already has in the worker is an aid in controlling the group. The children will be more obedient because they want to please the worker. (See page 58 for discussion of the therapeutic desirability of limiting display of rivalry.)

3. The group starts with a certain bond and loyalty to the worker which accelerates the development of group identity and spirit.

4. From personal contact, the worker already knows each boy and his problem intimately, and does not have to waste time reading the history and learning at secondhand what the child is like. Consequently

there does not have to be so much feeling one's way; action can be immediate and sure.

5. There are fewer problems of communication in collaboration because only the parents' worker and the child's worker are involved, instead of three workers.

6. It was further observed that five of the boys absolutely refused to attend camp unless they were assured of the direct physical presence of their worker. There would have been no question of how much another worker at camp could help them, since the boys would simply not be there to be helped.

Another important question was what happened to the ongoing treatment relationship between boy and his worker after camp. We were concerned about this when the experiment was undertaken. The therapeutic nature of the relationship might possibly be impaired—either by the trauma of having to deal with the worker as an authoritative parent-figure or by the greater intimacy engendered in the close living (in other words, turning the relationship into a personal rather than a therapeutic one).

In practice we find that all nine boys still in treatment have been able to resume their earlier therapeutic relationship without conflict. In each instance the relationship does seem deeper and more meaningful, but there are no signs of the child's trying to use it differently than he did before the camp experience. At camp the boys called the worker by his first name. Some have reverted to calling him "Mr." in the office. Some have commented that they would like to return to camp if the worker would be with them. There is no evidence to suggest that his involvement as group leader was in any way damaging to ongoing treatment. If anything, the sharing of a mutual living experience has strengthened the bond.

We are firmly convinced that, as a treatment technique, the experiment was well worth making and is worth further exploration.

BY DOROTHY McGRIFF

Working with a Group of Authoritative Mothers

ALL HOSPITAL SOCIAL workers have come into contact at one time or another with the hostile and demanding mother. The impact of the mothers' attitudes on hospital personnel linked with the staff's concern over the negative effect of the mothers on the patients has at times resulted in overt rejection of these women, thus compounding their need to demonstrate their control. The ensuing power struggle does little to create the therapeutic milieu deemed necessary for a patient's recovery and may induce regression. In addition, the tension created by this relatively small group can overshadow the co-operative spirit shown by other families to the extent that personnel tend to categorize all families as deterrents toward treatment.

Historically the role of the hospital social worker has included casework with relatives in an effort to maintain family ties. In the so-called "chronic" hospital, families tend gradually to restrict their visits over a period of years. Under these circumstances, and if in addition there are also valid shortages in social service personnel, it is understandable that the social worker's identification with the patient can become so strong that the duty to the family can become relegated to the background. Thus the family may become the "forgotten" ones. The aggressive mother does not submit to

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this neglect easily and may become more demanding and critical, creating painful and unpleasant scenes during her unwelcome visits.

Early in 1958, on one of the continued treatment wards of our 1600-bed Veterans Administration Neuropsychiatric Hospital it became quite evident that the problem of the "unwanted" mothers had reached a critical point. Approximately seven women created such unpleasant scenes during their visits that personnel ran for cover on their approach. When actual person-to-person contact was unavoidable, the mothers would make unreasonable and repetitive demands, complaints, and accusations and then add insult to injury by totally disregarding any explanations offered them. If, for example, their demands for admission to the ward prior to visiting hours were denied, they retaliated by staging temper tantrums, screaming their accusations, encouraging their sons and any other patients they could reach to disregard hospital regulations.

In spite of individual interviews with the ward physician a few mothers who complained bitterly about their sons' obesity continued to handfeed them cakes, candy, and sandwiches brought from home. At least one woman persisted in bathing and dressing her 40-year-old son in public. Ward personnel believed that little further progress could be achieved with the patients until the mothers could become less destructive and at the same time questioned how much longer they themselves could tolerate the weekly confusion and tension.

The problem per se was not referred to social service, possibly because at this stage it was inconceivable to ward personnel that anyone would willingly submit themselves to the hostile onslaughts of these aggressive women. Gradually, however, as the ward social worker, I became aware of the problem as individual women were referred to me either for specific casework services or as a means of getting them out of someone else's hair. As would be expected the women did respond to acceptance, but change in their behavior was negligible.

PURPOSE OF SOCIAL GROUP WORK

In a social service staff conference it was pointed out that group work has been used effectively in modifying behavior in many settings and perhaps the problems created by these mothers might be reduced through the use of the group process. It was suggested that more motivation for change might be achieved if the mothers could see some of the negative aspects of their own attitudes in others or perhaps they could more easily use constructive suggestions provided by their peers. Although the immediate goal of such a group would be the reduction of verbal battles between the mothers and ward personnel, the long-range purpose would be the establishment of more constructive relationships which could conceivably prove of therapeutic value to the patient.

In the preliminary planning for such a group it was recognized that each of the mothers has a great need to hold fast to her son and to participate actively in his treatment. They all tend to infantilize their sons and there is some evidence of well-established symbiotic relationships. They have great difficulty in conversation or in exchange of ideas—they are so busy talking themselves they never hear what anyone else is saying. Basically they have a tremendous need for acceptance but their own negative feelings for themselves forces them to re-

spond to others in such a way as to insure rejection. Their need for love and attention is also manifested in their well-developed hypochondriacal systems. In general they respond more favorably to men than to women, possibly because of their fear another woman might deprive them of their sons or might become a better mother, thus confirming their own inadequacies. With some stretch of the imagination the hospital itself might be conceived as the "good mother."

It was recognized that I, as the leader of such a group, should be prepared to accept a continued display of hostility, aggressiveness, and control. Although there would be at times a need for some degree of firmness and show of authority, we agreed that the basic approach should be permissive and accepting. In other words, the leader would become a good mother to the mothers. One of the first steps could be an expressed interest in their many and varied physical complaints. In order to meet their need for participation in treatment, information about proposed treatment plans should be made available to them. In order to lessen their sense of inferiority, whenever possible credit should be given for achievement or change. Since a male social worker was not immediately available for the group, it was important for me as the leader to be aware of the mothers' fears around the loss of their sons. My major contribution would probably be the ability to perceive and give credit for the strengths inherent in each of the women. Two major problems were foreseen: first, the tendency on my part to function as a caseworker to a number of individuals in a group because of lack of training and skill in understanding and utilizing the group process; and second, the possibility of my failure to accept the limited goal set for the group, namely the lessening of overt displays of hostility.

Skepticism in regard to any possible changes in the mothers and sympathy for me as the group leader were expressed by ward personnel, but it was mixed with a

willingness to try anything once and some anticipation at the prospect of being able to say "I told you so."

FORMATION OF THE GROUP

In order to test out the proposed group meetings, exploratory interviews were held with each of the mothers and their sons. The patients were essentially noncommittal, but the mothers responded with some enthusiasm to a meeting "just for mother." It was recognized with them that they too had problems as a result of their sons' illnesses, they needed someone with whom they could talk, and they might both give and receive help from other mothers who were in similar circumstances. It seemed significant to them that families in this as in other settings had found value in talking together about their hopes, problems, and plans.

Prior to the first meeting in April 1958, with the help of one of the ward psychologists, two rating scales were prepared, designed to show changes in behavior, presumably as a result of the group process. One scale, which is scored by the social worker following each meeting, is related primarily to behavior within the group. The second scale measures behavior toward the patient and personnel and is scored by the nursing staff at the beginning of group membership and at unspecified intervals later on, but definitely at the termination of group participation.

Only two mothers of the original seven appeared at the first meeting. For the next three months attendance was irregular, with some mothers attending only once, others skipping several consecutive meetings. It was not until September that concrete evidence of the formation of a group appeared. By that time a regular membership of five was established which was maintained for a number of months.

Some brief description of the mothers may be helpful. Their average age is 53. All five have serious financial problems and their regular visits to the hospital constitute a real monetary as well as physical sacrifice. Two are widows but the husbands of the other three are definitely relegated to the background. Only one of the women has been steadily employed outside the home. All but one have made repeated but unsuccessful attempts to have their sons at home. All five of the patients represented are single. In all instances the patient is the only member of the family sick enough to require hospitalization and each one has one or more siblings making a relatively healthy adjustment.

DEVELOPMENT OF GROUP INTERACTION

It is difficult to describe the early meetings. Only in the most liberal use of the term could the sessions be designated "group meetings." It was every woman for herself, including the leader at times. To make herself heard, each person spoke increasingly loudly which was strange because she was not especially concerned at having a response to her remarks. At times there would be as many as three monologues going on at one time, all directed toward me. If my attention was turned to one of the women, the others would occasionally talk to each other, but would usually clutch at me, move impatiently, or engage in some kind of disrupting activity in order to gain my attention. At times they cried easily but with comparatively little feeling.

In the beginning, as was expected, there was considerable discussion of physical disabilities, but the mothers also discussed their financial problems, their early marital histories, in fact, any subject that held little emotional investment for them. There were remarkably few complaints about the hospital and even fewer comments about their sons.

By September however there was a change. The meetings, always noisy, be-

came explosive. Ward personnel and policies were denounced with much feeling. Their sons were subjected to the same treatment. Weeping was the order of the day. They were more open in their impatience with each other. There were repeated demands that I uphold them in their opinions. I became the target of their hostility in more or less subtle ways. They repeatedly alluded to the fact that I could not understand because I was not a mother. There were unflattering comments about my appearance. I continued to get caught in intellectual traps and found myself trying to defend their sons or forgetting that the group was able to handle questions and comments better than I.

In spite of all this the women continued to come and gradually began to relate to each other. There was also a lessening of unpleasant interchanges between the mothers and ward personnel. It is not always easy to determine how and why group feeling is really born. Perhaps the group began to form as I became more relaxed and could trust the members to help each other. Another contributing factor could have been the discovery by two of the mothers that they had experienced many similar problems with their sons. A different kind of bond could have been formed as two or three of the mothers would express condemnation or disapproval of a fourth. Perhaps they also sensed a change in me. Instead of trying to express warmth toward the group I actually began to feel warm toward them. Cultural and professional standards can inhibit us in accepting and in describing our feelings toward our clients. To me, acceptance or warmth means love or the gift of love. For the most part I believe our clients attach the same meaning to this expression of feeling. It is possible that this group of unusually deprived women could only begin to relate to me and to each other after a rather long period of testing my willingness to give them love.

In addition, several more or less concrete elements were introduced about this time.

A new member joined the group. Unlike the other mothers she was very quiet but her lack of understanding and her overprotectiveness established her eligibility. A second element was the selection of a name for the group. This posed a problem for the members because they wanted the name to identify them as mothers yet they thought they should include me even though I was not a mother. At one point they considered calling themselves the Perry Point Mothers' Social Group, the "social" apparently representing an abbreviation of social worker. They finally decided this was a little awkward and omitted me from their title. With the name came a membership card entitling them to receive a pass to the ward one-half hour prior to the usual visiting hours. Obtaining a pass to the ward had been somewhat difficult for the receptionist was not always aware of the meetings but was aware of the unrealistic demands made by these women in the past.

The last element was the serving of coffee by members of the nursing staff at the beginning of each meeting. There could be endless speculation as to the meaning of this gift to them. Their reactions however were quite eloquent: surprise, almost disbelief, the question "Is it free?", pleasure, gratitude, and finally a tea-party atmosphere. Voices were lowered, there were fewer interruptions, they listened sympathetically to each other, and began to think positively and constructively about ways to help one mother handle a situation that had recently arisen with her son.

In succeeding meetings the desire for attention, the complaints and demands, the struggle for control have all made their usual appearance but with less intensity. Added to this has been a most exciting and unexpected development. In a recent meeting the discussion centered around the question "What is it I am doing to my son which prevents him from getting along well at home?"

It would indeed be gratifying to report that the behavior patterns have been al-

tered, that the mothers have gained insight, that the patients have improved as a result of the mothers' changed attitudes. Unfortunately this is not altogether true. The group meetings did serve their original purpose, that is, the reduction of open conflict. There are still minor skirmishes but at infrequent intervals. However, there have been other indications of changes, hopefully basic ones. For instance, one mother has reduced her visits voluntarily to once every two weeks rather than twice a week. Although this was not discussed specifically in the group, we could speculate that she is less threatened by the "good mother" hospital. Another mother as a direct result of group discussion was able to refuse to buy extra food for her son at the canteen, suggesting instead that he might feel more independent if he bought something for her.

EFFECTS OF GROUP ON MOTHERS AND PATIENTS

The decision to form the group was based on two assumptions: first, the women might be motivated to change as they became intellectually aware of the attitudes of other mothers; second, suggestions and interpretations might be more readily incorporated if presented by the mothers themselves rather than through the staff. There is no doubt as to the validity of these two assumptions, but it is rather pleasant to find corroborating evidence. For example, one mother had carried on for years a losing but sharp campaign to prevent her son's participation in industrial therapy. According to her, personnel was paid to work but patients should only engage in recreational activity. It came as something of a shock to her to find that the other mothers in the group considered work a therapeutic agent. Gradually her complaints about her son's assignment were hedged with concessions and apologies. It is hard for her to give up this conviction and it is possible she will never really understand it, but at least she is less vociferous in her denunciations.

The meaning and value of the meetings to the individual mother vary widely. One mother either lost interest or was too threatened by the more verbal members; her attendance ceased without explanation. Of the others only one appears to have gained any insight into her relationship with her son. The remaining members apparently use the group to gain acceptance, information, and a release for their hostile and anxious feelings.

It is difficult to evaluate the effect of the meetings on the patients. There have been no marked changes, either positive or negative. They are quite aware of the dates of the meetings, frequently reminding me that I can expect their mothers to attend. They nearly always show considerable interest in the subject matter discussed, often questioning their mothers at length. It is interesting to note that the patient whose mother reduced her visits is the only one who has shown some slight improvement. Naturally there are many other factors which could be contributing to this change.

Taking into account that the reduction of pressure on ward personnel has had a reciprocal effect on the mothers, it is still the concensus that the group meetings have contributed significantly to the changes noted. However, an examination of the data available from the two rating scales described earlier suggests trends toward more positive behavior rather than statistically significant change. In general the Ward Personnel Behavior Rating Scale showed a slight increase of positive behavior. In this scale, permitting a total score of 90 points, the average rating for the mothers in May was 61. In December it was 66. For individual mothers this represented a positive behavior change of 2 to 10 points. For one mother only there was a negative change of 9 points. This same slight trend toward more positive behavior within the group itself was seen in the ratings completed following each meeting. With a possible score of 24, the average rating for the mothers in May was 14; in December it was 16. No definite behavior

patterns were seen in the graphs of rating scale scores plotted over meetings, or, in other words, no consistent changes in behavior occurred as the meetings continued. There seemed to be a tendency on the part of the mothers to become more negative in their behavior after the first few meetings, followed later on by an increase in positive behavior, but the timing and the degree of change were essentially different for each mother. It is evident that the size of the group, the comparatively small number of meetings and the rather marked measured differences between the mothers preclude any definitive findings, but the trends noted may suggest a more formalized study of this approach to the authoritarian mother.

A critical analysis of my role within the group would probably leave little doubt that my primary identification in the field of social work is that of a caseworker. As we become more generically minded, the gap between the group worker and the caseworker should be lessened and the skills interchangeable. With this type of orientation we could expect less difficulty during the formative period of groups and perhaps greater progress. For this particular group and at this stage in their development the leader should be assuming less prominence; however, it should be noted that I am still the giver of information, the whipping boy, the good mother, the final authority. At any rate the group apparently answers a need for these women. For ward personnel it has meant a reduction in conflict and is seen as a therapeutic resource for other hostile mothers. For a social worker there is a great challenge in the application of generic skills.

BY IRVING MILLER

Distinctive Characteristics of Supervision in Group Work

THIS PAPER WILL attempt to develop and illustrate the following interrelated propositions:

1. The conceptual framework, principles, and methodology of supervision in group work do not adequately take into account the influence upon supervision of the nature and distinctive social characteristics of the worker-group relationship and of the social services provided by group workers.

2. This inadequacy is in part a consequence of the utilization of the caseworker and casework as the role model and service situation to develop supervisory theory and practice.

3. Group workers can make important contributions to the development of supervisory practice in group work to the degree that they pay closer attention than heretofore to the specifics of supervision in group work and relinquish the tired and intellectually debilitating notion that the most important and significant element in supervision is what can be called "generic."

Supervision in group work has been a somewhat awkward subject for discussion. We have tended to regard it as a special problem in bringing into more harmonious relationship the mundane necessities of supervisory practice on one hand and standards believed to be desirable and professionally sound on the other. Many experience frustration as they contemplate the seemingly unbridgeable gap between what they have been taught to regard as good practice—what ought to be done—and the kinds of practice standards imposed by reality. Authoritative formulations of principles and methods of supervision for group work services, as well as conceptions of the respective roles and functions of worker and supervisor, do not seem to work out consistently in practice. The attitude of many group workers appears to be that the books and "theories" make the most sense to teachers and their students who are in a highly specialized, controlled, and protected situation and thus able to perform supervisory tasks as they should be performed. Recording and the regularly scheduled supervisory conference, for example, are luxuries which agencies either cannot afford or for which they are not yet (and may never be) professionally ready.[1]

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[1] It has been frequently observed that professionally trained group workers are rarely provided with the opportunity to spend nearly as much time in supervisory conferences, recording, and so forth, as when they were students, or as much as they believe would be professionally desirable.

As to the latter point it may be said parenthetically that some of us have been more disposed to insist that we cannot afford not to do this or that than to ask whether, in fact, the effort required for "good" recording is worth the time and cost in relation to other needs and claims upon the agency. Much recording, and therefore much time, is filed into unproductive and unread obscurity. To the extent that this is true it ought not be dismissed by a virtuous assertion that the problem is solved when you make sure that records are read and used as they should be used. Perhaps the solution to the problem lies as much as anything in re-evaluating the place and use of recording as such.

BACKGROUND OF SUPERVISION IN GROUP WORK

What there is of what may be called official and standard texts on supervision in group work provides little help in achieving conceptual clarity and connecting theory to practice. Actually very little is written about supervision in group work. The most recent of the few texts was published in 1950,[2] and the number of articles published in professional journals in the last fifteen years hardly exceeds a dozen.[3] Much less, if anything, has been written that is prob-

lem-focused, challenges and critically examines ideas and actions, adequately describes practice, or takes into account the agency as a system of social relationships in which there are inequalities and differences in influence, power, function, and responsibility among the various people who are part of it. Our literature has tended to be anecdotal and has emphasized values, value preferences, and value commitments, treating them as if they were principles which describe reality rather than a guide or a goal. It tends, for example, to obscure and deny—by value-laden, psychologically seductive, and goal-oriented formulations —the plain fact of power and authority as an inescapable concomitant of the supervisory role and the worker-supervisor relationship.[4]

The prevailing customs and modes of thought in group work concerning supervision—the central emphasis placed upon "relationship," "self-awareness," "feelings," and so on—seem to be drawn from what has been developed in casework. Casework represents a style of thinking and doing that has grown out of the master-apprentice approach to learning and a distinctive intellectual and social tradition.[5] Group work has somewhat different intellectual and social traditions. It has roots in progressive education and in a milieu approach to

[2] See Hedley S. Dimock and Harleigh B. Trecker, *The Supervision of Group Work and Recreation* (New York: Association Press, 1949); Sidney Lindenberg, *Supervision in Social Group Work* (New York: Association Press, 1939); Margaret Williamson, *Supervision—Principles and Methods* (New York: Woman's Press, 1950). *See also* Ray Johns, *Executive Responsibility* (New York: Association Press, 1954), Chaps. VII and VIII; Harleigh B. Trecker, *Group Process in Administration*, revised and enlarged (New York: Woman's Press, 1950), Chap. IV; Gertrude Wilson and Gladys Ryland, *Social Group Work Practice* (Boston: Houghton Mifflin, 1949), Part IV.

[3] Particular reference is made here to *The Group*, published by the American Association of Group Workers, and *Social Work*, published by the NASW. The former was discontinued and absorbed by the latter, the first issue of which appeared in January 1956.

[4] Dimock and Trecker, *op. cit.*, p. 24: "The relationship . . . will be one of leadership, cooperation and mutuality, rather than one of authority or that between superior and subordinate. Administrators, supervisors and volunteer workers do not constitute a hierarchy in importance or authority, but represent a division of labor among colleagues in a common cause."

[5] In recent years caseworkers have begun to question and re-evaluate supervisory practice in casework. For example, *see* Lucille N. Austin, "An Evaluation of Supervision," *Social Casework*, Vol. 37, No. 8, (October 1956), pp. 375–382; *see also Casework Papers 1956* (New York: Family Service Association of America, 1956), pp. 3–19; Arthur L. Leader, "New Directions in Supervision," *Social Casework*, Vol. 38, No. 9, (November 1957), pp. 462–468; Ruth Ellen Lindenberg, "Changing Traditional Patterns of Supervision," *Social Work*, Vol. 2, No. 2 (April 1957), pp. 42–46.

service. Its action arena includes provision for normal leisure-time needs, and the service is so perceived by the consumer and the community. This is the way it is, and this ought to influence and be reflected in the supervisory approach and the techniques developed for supervision of group work services.

Supervision in casework has been characterized by a special emphasis upon the psychological and intrapsychic aspects of the supervisory function and the importance of developing self-awareness and insight. While this may result in some tendencies to re-enact in the supervisory relationship the worker-client relationship—to produce dependency, inhibit creativity, blur the purpose of supervision, and dull its administrative edge—nevertheless, and despite the risks, a case can be made to justify this orientation. The arena of action in casework typically consists of the personal problems people bring, their personal and interpersonal troubles and feelings and attitudes, which need to be put back in tune. If nothing else, this helps to explain the particular flavor and style of supervision in casework, since it is reasonable to expect that the content and form of service will affect the content and form of its supervision. However, one cannot describe the form and content of group work services in the same term as casework.

The worker-supervisor relationship has assumed central significance comparable to the worker-client relationship as a means of achieving the purposes of supervision and thereby the purposes of the agency. However, this does not require that the group worker (or caseworker) have a dependence and place emphasis on this as if relationship were the very goal of supervision. Sometimes workers learn in spite of the supervisor and the quality of the supervisory relationship. They can make progress even when the relationship is professionally poor and personally unpleasant. Moreover, the importance of relationship—of the emotional and comfort components in learning—does not

require that the instructional, information- and advice-giving aspects of supervision be minimized. This point is of particular relevance to group work in view of the background characteristics, training, and experience of most of its direct service givers.

Similarly, the importance of understanding behavior and of becoming self-aware and self-understanding so that we may help others better does not require that we think and act as if the very purpose of supervision were to develop self-awareness and self-understanding for its own sake. In a sense group workers have inadvertently fostered a kind of mystique about supervision and what it means; about the self-improvement and self-understanding it offers the young worker and the novice. As a consequence, unrealistic and inappropriate expectations of supervision are fostered and maintained. This again is particularly relevant when one considers that most of the direct service givers in group work are young, inexperienced, and untrained persons. They sometimes come to group service agencies with troubles which do not necessarily impinge directly upon practice and which should be taken elsewhere. Sometimes they discover their own difficulties only because a supervisor could not resist the tantalizing temptation and quiet satisfaction of being the one to discover and disclose another person's personal troubles. This is unhelpful and unbecoming. The tendency to focus on the personality of the supervisee will diminish or weaken the more proper concern with giving active, supportive direction to actual work with groups—giving service, developing program and program skills, and so forth.

Group workers have hardly gone further in developing a point of view and methodology for supervision than to assume that supervision in social work is generic, that fundamentals are fundamentals, that relationship is after all still relationship, that the principles are all the same except as they need to be adapted to the individual

situation and individual supervisee. But there is much more to supervision than the individual worker and the individual supervisor. The so-called generic approach can obscure and inhibit creative thinking under the guise of an integrative and holistic approach to theory and practice. Actually it is more useful to think of supervision in the context of the function of the agency and the characteristics and requirements of the professional role and relationship—*i.e.*, the characteristics and purposes of those being served, those providing the services, and the nature of the service itself.

INFLUENCE OF PRACTICE
ON SUPERVISION

This brings us to a consideration of some specific aspects and social characteristics of group work practice which should influence and modify goals, methods, and techniques of supervision. In the typical casework situation what goes on between the caseworker and the client is visible to others in the agency only as the caseworker reveals it through records, verbal communication, and the like. The client usually communicates only with the caseworker and not with other clients, staff members, and so on. What goes on between the worker and the group is directly visible to many people who in various ways can and do influence what does go on between the worker and the group. It is highly visible to other workers and to the group members themselves, who communicate with each other, with other agency members, and with interested persons outside the agency; finally, it is fairly visible to supervisors and others who are concerned with whether the service is being properly rendered, and who are indeed accountable for it.[6] It is pos-

sible to know in significant ways what is actually going on in a group without reference to narrative or process recording or the supervisory conference. Group members show up or do not, and their attendance falls into more or less regular patterns. Much can be inferred from this revealing and quite public behavior. Members are usually acquainted with the worker's supervisor, sometimes even with the agency director, and have some idea of their respective status and functions. They are seen in and around the building, attending or participating in programs. In many agencies members have direct access to supervisors along both formal and informal lines, and they have their own effective ways of letting supervisory staff know what is or is not going on and what they like and do not like about it. Supervisors will often assert that they just know, or can sense or "smell," what is really going on in the agency and how members feel about each other and the worker, without reading records or discussing it. It seems to come to them by the very nature of the group work service situation; they somehow know things and are aware of subtleties that rarely appear—are probably more often concealed—in process records. They know by walking through halls, "covering" the building, dropping into the lounge or game room, being friendly with members, and even occasionally being invited into group meetings. This state of affairs is hardly similar, in either degree or kind, to a typical casework situation.

In addition to the visibility to others of the service and professional relationship, there is also the fact of power and differences in power between actors in the helping situation, to influence and affect what goes on. In the typical casework situation the client is highly dependent on the worker, has relatively little power to influence him, and is participating essentially in a take-it-or-leave-it relationship. This is not said here in a negative or critical sense, as if something should or could be done

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6 Lloyd E. Ohlin, "Conformity in American Society Today," *Social Work*, Vol. 3, No. 2 (April 1958), pp. 58–66. Particularly pertinent is the author's penetrating discussion and analysis of the problem of supervising work which cannot be observed directly.

about it. The point is, however, that by the very nature of the respective helping situations the casework client tends to be much more dependent than the group upon the worker's professional competence and integrity, as a control on his (the worker's) behavior. To express it in another way, the worker-group relationship is one in which members can exert a relatively greater influence on the worker and produce more conforming behavior on his part than is usually the case in the worker-client relationship.

Members of a group, and the group as a whole, have a power of their own which balances that of the worker. This frequently exerts more influence upon his behavior than is acknowledged or taken into account. The fact that the worker is supposed to behave in democratically oriented and professionally objective ways and to help the group become self-determining does not alter his power to influence, to manipulate, to give and withhold important rewards; nor does it alter the capacity of the group to bend the worker to its will in ways not necessarily consistent with professional purposes. The group gets to know the kinds of subtle and overt pressures under which a worker operates, the kinds of activities that are subtly or openly preferred by the agency, the importance in this light of participation in certain agency-wide or intergroup activities. They know, too, that the worker receives direct or indirect approbation or criticism depending upon whether or not his groups participate. Even in situations where care is taken to reduce pressure on the worker, the inevitable need to explain or analyze why a group failed to participate in a carnival or send a delegate to a council or other agency-wide programs exerts considerable pressure. This provides the group with an opportunity to exert influence on the worker's behavior by withholding or granting their own participation and conformity to perceived agency preferences. The consequences may not be sound or even anticipated, and while this kind of

situation may not be intrinsic to the function and role of the worker, it appears to be intrinsic to the social context of the worker-group relationship. Thus there is a good deal of politic accommodating and "log-rolling" between worker and group that is not usually acknowledged, recorded, or taken into account by the worker, the supervisor, or the agency.

These observations concerning "visibility" and "power" in the worker-group relationship may well overstate the case and require more documentation. However, they do seem to have direct relevance to the kind of stance or approach group workers ought to take (one might hope, a more independent and flexible one) toward supervision in group work. Some implications for the modification of characteristic methods and techniques in supervision seem to be fairly apparent.

HOW SUPERVISION SHOULD BE MODIFIED

1. *Recording.* Much of what has been said suggests the desirability of re-evaluating attitudes toward recording and a possible change of method in dealing with it. Conceptions as to its place and use in supervision have been far from clear; as a consequence group workers have tended to compare themselves invidiously with other social workers who—in other service contexts—characteristically record more often and more fully. Some have seen recording as if it were of the essence of professional practice rather than a differentially utilized instrument for achieving specifically stated purposes. Most, if not all, professions keep records of some kind which are presumably suited to their own purposes and particular social situations. The physician, whose record of many contacts with a patient may consist of brief entries on a small file card, is not less professional because he does not use the process or narrative record. How many psychotherapists keep records of their psychiatric interviews? Some do, some do

not (it is said of some that they do not even listen, much less record). It is doubtful whether social workers in private practice record—if at all—in a fashion remotely resembling the usage they followed, or were required to follow, as agency workers. While some of us may be critical of such professionals, few would be prepared to assert that they are less, or not at all, professional because of their recording practices. Yet many group workers feel they are really being professional to the degree that there is process recording in their agencies. Instead of an assumed categorical imperative about what is "good" or "bad" professional practice, recording practices in agencies should be judged in terms of the particular needs or purposes.

Two further and related observations may be made but not elaborated here as to recording in general. The role of the agency and the need for accountability are much involved in the requirement to record. This is somewhat reinforced by the observation that in professional situations where there is little if any recording, accountability to or by an agency is usually not involved.

Second, even within an agency situation and a context of accountability, recording may fulfill different kinds of requirements and have certain latent functions. It is possible, for example, that one of the latent functions of recording in a casework situation is to protect the client from the risks inherent in a helping situation which is not visible and is controlled by and protective of the worker. In the relatively visible group work situation, placing the worker's perceptions on record may serve to protect him, in a way not necessary in casework, from the biases and perceptions of many other people who get "into the act" of group work and make claims and judgments on what is or should be happening in the group. This factor in the group situation, combined with others already alluded to, perhaps helps to explain the tendency of workers to be highly selective in recording things they think will please

the supervisor and be consonant with actual or conjectured expectations.

What is needed is the development of standards and methods of recording that are explicitly related to specific purposes and service situations. The virtues of process recording are not overriding; its use should be selective and justified by specific purposes and functions. Moreover, greater emphasis needs to be placed on objective kinds of recording and the systematizing and classifying of what is to be set down. A more imaginative use of attendance figures is a case in point. Who attends and how often, and the individual pattern of attendance, might tell as much as and sometimes more than an unfocused account of how a worker felt about things and how members presumably felt about each other. There ought to be developed a basic, minimum, across-the-board outline for recording which can be handled quickly, and to which more can be added as needed. Too much recording is done for the sake of appearances; it is filed, forgotten, perhaps never even read. Too little is done in response to clearly formulated purposes and specifically stated needs.

2. *Use of didactic method.* The educational, character-building, constructive use of the leisure-time aspects of our service, as well as the background characteristics of most of our service-givers, points to greater emphasis than is now apparent upon the straight didactic or teaching aspects of supervision. This means the use of group methods to transmit program skills and suggestions directly, and to teach substantively about group processes. It is not enough merely to put workers at their ease and help them work out their feelings. They need to be shown how to do things: how to help a group and work out a program. This is easier to connect with and goes a longer way than an attempt on a purely verbal level to help the worker become less anxious and more free-wheeling. The reluctance to be direct, to teach, and to show is probably related to concep-

tions or misconceptions of the worker's role in the group. The concept of the role as an *enabling* one has been permitted to subvert the worker's obligation to be an agent of change in the group. In this connection it is curious that we have abandoned the use of the word *leader* in favor of *worker*. If the shift is for the sake of semantic clarity, that is one thing; if it reflects the idea that the worker should not exert a strong leadership role, that is quite another, and something which would need to be questioned.

3. *Observation.* The use of observation as a supervisory method has been either suspect, neglected, or rejected, and this does not seem to be justified. Its alleged inappropriateness is exaggerated and implies a static conception of the supervisory role. Whether or not it makes a worker nervous, changes the group constellation, and affects the very process it purports to observe, is a matter largely of degree, depending upon time, place, situation, and person. The climate of a group work setting does not make such a procedure either very strange or out of context. Observation of a worker's activity takes place in any case on an informal, not a deliberately planned basis. The question is whether it is sound to permit the presumed and unverified disadvantages of observation to outweigh its possible advantages and the opportunity it provides to learn things that could not otherwise be known. Observation is used in other professional situations not dissimilar to our own, and we ought not assume, as many do, that it is a thoughtless, capricious, disturbing, or professionally demeaning procedure.[7]

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[7] Wilson and Ryland, *op. cit.*, p. 547: "Record writing makes it unnecessary for the supervisor to observe the worker with the group. Observation by the supervisor is a poor substitute for record writing by the worker, and there is considerable question as to its value under any circumstances. . . . The supervisor who feels that it is necessary to supplement the record with observational visits . . . is unable to relinquish the necessary authority . . . [and] tends to relegate the worker to the infantile level and impede his progress."

4. *Direct help and teaching.* This offers possibilities in the actual work situation which should not be despised or put aside. There are many supervisory situations in which this can be done, and for which in fact it is a particularly suitable, useful, possibly a preferred procedure. The very nature of the camp and similar settings permits direct help and indeed may very well require active use of it. The "right-here-and-now" quality of a camping service and the necessity somehow to survive the summer with as much grace as possible makes it quite risky to rely exclusively or heavily on across-the-desk supervision.

5. *Supervisory conference.* The individual conference has been virtually the keystone of the arch supporting the structure of supervisory methods and techniques. Indeed, it is difficult to think of supervision in social work without providing a clear and important place for the conference. It provides a valuable opportunity for teaching, interpreting, helping the worker to enlarge his understanding and do his job better—in short, for achieving the purposes of supervision. The conference, however, is not identical with supervision. It, too, is an instrument which must be used differentially and according to purpose, person, and place. The regular uninterrupted weekly conference is not in itself the hallmark of good supervision. Ritualistic and unfocused adherence to it can bring confusion between means and ends and transform the administrative and educational virtues of consistency into the defects of a formalism without content.

Just as all group activity may not be a good thing—can indeed be quite bad and destructive—so the conference is not, by itself, a good thing or without risks. Individual conference can be helpful and meaningful only as it is used purposefully, to enhance objectivity and stimulate the worker to learn and improve his practice through the content the supervisor brings to it. The conference can be useful only when the worker's intrapsychic problems are

left alone and his behavior and feelings identified and explored solely in relation to their consequences in practice. It has true value only as we avoid using it as an emotional hitching post for the supervisor's or worker's personal problems, and only as we acknowledge the primary responsibility of the supervisor to give leadership and substance to it.

Finally, it would help a great deal to give up the sentimental sham that the worker-supervisor relationship exists between equals, or between professional colleagues who happen to have different functions and responsibilities. This kind of well-meaning distortion obscures the power and authority inherent in the supervisory function. To assert the reality of that power and authority is not to deny social work values, but makes it possible to affirm with some validity that such power and authority are most effective and productive when used in an objective, democratic, responsible, sensitive, and decent fashion. To insist that what ought to be an attitude and feeling tone in supervision is in fact a social reality, distorts the supervisory function and can only detract from the possibility of using supervision creatively.

No doubt this limited analysis of some specific aspects of supervision omits much that is relevant. However, we cannot treat such a subject with completeness, taking into account all factors. We can only think in such terms, while we go about the more fruitful business of trying to understand and elaborate a little at a time. If there is overstatement or careless criticism here, it is probably owing in part to a greater value being placed upon questioning than upon caution; upon the discomfort of uncertainty than upon the comfort of unwarranted self-assurance. We can only develop theory and practice as we test and clarify each and are willing to change.

BY PATRICIA BEALL AND MORRIS GREEN

Role of the Social Worker in a Children's Diagnostic Service

CURRENTLY THERE IS great interest in improvement of the quality and availability of ambulatory patient care. Many opportunities are being created for extension and enhancement of social work services as outpatient departments play increasingly important roles in medical education, research, and service. This paper is concerned with the role of the social worker in the pediatric-diagnostic clinic of the recently opened Children's Outpatient and Diagnostic Center in James Whitcomb Riley Hospital.

ORGANIZATION OF CLINIC

Children are referred for consultation by physicians throughout the state. Their problems cover the whole spectrum of pediatric interest. The staff of the clinic seeks to provide rapid and comprehensive diagnosis and recommendations for treatment. Even in the case of complex diagnostic and therapeutic problems, it is usually

possible for new patients to receive a complete evaluation in one day. Certain types of problems are scheduled on specific days according to the referring diagnosis or complaint, for example, children with heart disease on Mondays, convulsive seizures on Tuesday, metabolic, endocrine and cerebral palsy on Wednesdays, and so on. By having special diagnostic teams available on these days patients may be seen in consultation by the appropriate specialists and have X-rays and laboratory examinations performed in one day. At the conclusion of each day the director of the clinic communicates to the referring physician the diagnostic conclusions reached by the staff and their recommendations for treatment.

The clinic is also concerned with the education of senior medical students, nursing students, pediatric house officers, and, in the near future, social work students. An active program of research is also under way.

The director of Children's Outpatient Clinics, a pediatrician, is responsible for the over-all development and operation of the clinic. The head nurse is in charge of the nursing and clerical functions and personnel. The role of the clinic nurse has been the subject of another report.[1] Student nurses are supervised by the clinic nursing instructor, who also serves as clinic public health co-ordinator. The clinic social work-

[1] Julia Ann Schade, and M. Green, "The Challenging Role of the Outpatient Children's Clinic Nurse," *American Journal of Nursing.* To be published.

ers are members of the Social Service Department of Indiana University Medical Center. Two social workers work full time in the pediatric-diagnostic clinic. Additional social workers are assigned to the various children's specialty clinics.

Pediatric residents are assigned to the clinic full-time for one rotation period during each of their two years of residency. Beginning this year a third-year pediatric residency, full-time in the clinic, has been arranged. At the conclusion of the resident's rotation in the clinic he may continue to follow children since each physician has certain afternoons throughout the year during which time he comes to the clinic to see his follow-up patients; thus, continuity of care by the same physician is assured. Senior medical students are assigned as externs to the clinic for a five-to six-week period.

New pediatric-diagnostic patients are seen promptly by appointment at 8:00 A.M. each day by either a pediatric resident or a senior medical student who takes the history and completes the physical examination. Six or seven new patients are seen each morning. A student nurse assists the doctor during his examination. Each new patient is screened for hearing and visual defects by a staff nurse. A consultant in speech and audiology is available in the clinic to evaluate speech problems and to assist in the further study of auditory difficulties. A routine blood count and urinalysis are also performed on each new patient. Following these examinations, the doctor presents his findings to the clinic director and to other members of the senior staff in a teaching-disposition conference. The child may also be seen by the conference group. Participating in the conference are the medical students, pediatric residents, student nurses, staff nurses, clinic social workers, and other medical consultants such as the child psychiatrist, the speech consultant, or the neurologist. These sessions usually begin around 9:00 A.M. and last until noon or later. As the doctor presents his findings, that is, the history

and the physical examination, the material is written on the board by the clinic director, who is the session leader. Observations and comments may be added by the nurse or the social worker. Differential diagnosis is then discussed and a plan made for further diagnostic studies or a treatment plan.

TEAM COLLABORATION

Team care and co-operation are a vital part of the clinic's approach to total patient care. The team may consist variously of the pediatrician, the nurse, social worker, and the psychologist working closely with the local physician, public health nurse, school authorities, and/or the community social agencies. Actually, this may be considered analogous to the recognized concept in child guidance clinics with the medical person as the head of the team. In the pediatric-diagnostic clinic this happens to be the pediatrician, whereas in the child guidance clinic it is the child psychiatrist.

Many children are evaluated and treated in the pediatric-diagnostic clinic who in other settings might be first seen or followed in a child guidance clinic. There are several reasons for this: first, like most child guidance clinics the one at Indiana University Medical Center has a long waiting list and cannot see new patients for several months. Second, the diagnostic clinic is designed to provide learning experiences for senior medical students and for pediatric house officers who will soon be entering private practice where they will be consulted regarding many psychologic problems similar to those presented by patients in the clinic. Frequently in the past, these problems have been considered as "psychiatric" and, therefore, not within the competence of the nonpsychiatric physician. Many of these children can, however, be treated effectively by the properly trained physician. This has been demonstrated repeatedly in this clinic.

For many parents, treatment in a pediatric clinic is more acceptable than that in a

child guidance clinic. This seems to be particularly true when children present "physical" symptoms such as headache or abdominal pain even though these have a psychologic etiology. In part, this is because the pediatrician is considered to be a doctor competent in the recognition and management of physical illness; parents are often able to accept his statement that the symptoms have an emotional base.

It is not within the scope of this paper to go into the principles, techniques, and skills involved in the diagnostic and treatment process in these cases. These have long been used by social work. Physicians in training have an opportunity to develop these skills in this clinic, particularly in interviewing. Their initial doubt changes from amazement to conviction as they experience results with this approach. As one of the residents commented, the thing that he really learned in the clinic was that something *could* be done with these problems by a nonpsychiatric physician. The clinic staff has had considerable success in helping children with complaints of psychogenic etiology. Following a period of treatment, children with abdominal complaints, psychogenic seizures, tics, headaches, nervousness, and the like have become symptom-free. Gradual change in family relationships has contributed to improved emotional health of the whole family.

CASEWORK FUNCTION OF CLINIC SOCIAL WORKER

The clinic social worker has had both a casework and an educational function as a member of the clinic diagnostic and therapeutic team. No special explanation is given to medical students or house officers of the social worker's role—just as no special interpretation is given of the role of other consultants. It is apparent that she is there because she has a contribution to make to patient care. This method, in which the contribution of the social worker is taken for granted, in contrast to some clinics where the role of the social worker is interpreted in detail, has worked out well. The social worker in this clinic has felt no need to prove herself or to be defensive about her contribution. Rather, she has found that the physicians depend greatly upon her special skills and that they consult with her frequently.

The clinic social worker participates actively in the daily teaching conferences at which the senior medical students and residents present their findings to the clinic director. As seems indicated, she raises questions regarding the family and social history in order to clarify points. In some instances, the inadequacy of the history obtained by the medical student, particularly in the social and emotional areas, does not permit a comprehensive diagnosis to be established. Many medical students initially seem to be afraid to make a conscious appraisal of the personality of the parents and child or to become involved in these aspects of the history. They sometimes feel that if they cannot use the terms "normal," "well-adjusted," "sincere," or "stable," they would rather not say anything "bad." In this event the social worker may be requested to interview the parents further either alone or preferably accompanied by the student. Additional history and impressions are then reported back to the group conference which, in the meantime, has moved along to consider other cases. If the social worker has received additional history or information from a local social agency, she also presents this material as appropriate to the conference.

The teaching conference arrives at a tentative diagnosis and plans for additional work-up. If additional X-rays, EEG, EKG, or other laboratory procedures are needed, they are obtained the same day. Then a plan of treatment is set up. This may be: (1) referral back to the local doctor or other local resource, (2) referral to be followed in the pediatric clinic, (3) admission to the hospital, or (4) referral to a specialty clinic at the Riley Children's Hospital, such as orthopedic or neurosurgical. An effort is made to keep patients in the general

pediatric clinic unless it would be to the patient's benefit to be followed in a specialty clinic.

TREATMENT PLANS

The findings of the initial work-up and plans for treatment are discussed with each family by the clinic director, usually in the company of the social worker and frequently the medical student. In some instances the clinic director will present to the parents and/or to the child the general impression of the staff. The social worker may then follow through to insure that the parents have a full understanding of these impressions and to see if there are additional questions. This permits the clinic director to move on to talk to the next parent. In cases in which a referral is made to a child guidance clinic, the social worker helps prepare the parents for this referral.

If the child is admitted to the hospital or referred to a specialty clinic and there is need for continued casework services, referral is made to the social worker assigned to the particular inpatient service or specialty clinic. When possible, families are introduced to the new social worker who will be seeing them.

Just as a letter is written by the clinic director to the local medical doctor regarding the findings and recommendations of the pediatric-diagnostic clinic evaluation, the social worker communicates to the local social agency if such is involved, outlining the findings and recommendations of the staff. The nursing instructor writes to the community public health agency as directed by the medical clinic staff. During the treatment of a patient, additional progress letters, as indicated, are sent by the clinic director to the local doctor and by the social worker to local social agencies or schools. Since so many children with school problems are seen, the social worker frequently asks for school reports and works in close co-operation with public and parochial schools throughout the state. Thus, the caseworker in the clinic has an integral role in diagnosis, treatment, and in furthering co-operation with community resources throughout the state.

If the patient is to be followed in the clinic, the case is assigned to a pediatric resident. Although he may follow the child and the family alone, in many instances a plan is set up with the physician seeing the child while the social worker sees the parents or parent on a weekly basis. In a few instances, particularly with adolescent girls, the plan of treatment has been for the child to see the clinic nurse as well as the doctor, one parent the resident, and the other parent the social worker. In most instances the physician deals directly with the adolescent girl by himself. Recently one of the social workers has been seeing adolescent girls with such problems as obesity and headaches in conjunction with one of the clinic doctors. In one or two instances, the social worker has had follow-up interviews with parents while the child has not been seen. The usual clinic fee is charged for these sessions. As time permits, the social worker observes the child in the play area in the waiting room or with his parents before or after the interview. There is consultation with medical and nursing staff following each treatment interview. Cases are not referred by the medical staff to the social worker as something apart from medical care; medical and social services are in all instances collaborative and interdependent.

TYPES OF CASES

From the latter part of September 1958, through June 1, 1959, the caseworker has been involved actively in 295 cases which represent about one-third of the new patients seen in the pediatric-diagnostic clinic. At the end of the first year, 1,015 children had been seen as new patients. The number of referrals steadily increases.

Table 1 categorizes, according to the chief complaint, the cases in which the social worker has participated in either a diagnostic or treatment capacity. These categories

have been arbitrarily established to give some kind of characterization to the type of medical problems in which there is close collaboration between the clinic social worker and the medical staff. The vast majority of cases had a multiplicity of complaints and could have been placed in more than one category. In almost all the situations in which the social worker participated, there was a strong social and emotional component in the illness.

TABLE 1
CATEGORIZATION OF CASES BY CHIEF COMPLAINT

Evaluation of physical and mental development	68
Convulsive seizures	52
Physical complaints on psychogenic basis[1]	37
Not doing well in school	35
Behavior problems[2]	32
Cardiac conditions	21
Orthopedic problems	16
Plastic surgery problems	8
Speech problems	5
Miscellaneous problems[3]	21
Total	295

[1] Includes headaches, vomiting, abdominal pain, obesity, tiredness, tics, and so on.

[2] Includes sexual problems, encopresis, enuresis, lying, stealing, temper outbursts.

[3] Includes bleeding tendency, asthma, eye problems, multiple anomalies.

EDUCATIONAL ROLE OF CLINIC SOCIAL WORKER

The clinic social worker has an educational responsibility over and beyond her function as a caseworker. In practice these two responsibilities are closely related and are interdependent. As in all clinical practice diagnosis, treatment, and teaching occur concurrently and cannot be separated.

In the disposition conferences the social worker contributes her knowledge of local resources and social conditions. Medical students and student nurses have often observed the diagnostic and treatment interviews conducted by the social worker. This has permitted direct observation of the techniques of interviewing. There have been numerous informal sessions and discussions with individual medical students, residents, and student nurses regarding the material brought out and general management of patients. In a few instances medical students have been able to follow patients through the treatment period.

One case involved a 9-year-old boy who had abdominal pains which were causing absences from school. On a regular basis a social worker saw the mother while the medical student saw the child. The medical student consulted with the social worker and clinic director before and after each treatment interview. After a few interviews the child was symptom-free and attending school regularly. The medical student was impressed with these results.

Unfortunately, because of the comparatively short period that the medical students are currently assigned, only a few have had an opportunity to follow patients long enough to gain adequate experience or skill in interviewing as a treatment method. Many have expressed the wish that they could follow patients longer. Efforts are being made to arrange for this. Staff nurses have gained, by direct observation and participation, a better understanding of patient behavior and what is involved in interviewing. In a few cases a staff nurse has been seeing a child on a regularly planned basis. These interviews have been discussed with the social worker as to the meaning of the material and the use of interviewing techniques and skills. The pediatric residents have had an adequate opportunity to follow their patients over a long period of time.

There is an especially close collaborative relationship between the pediatric resident and the social worker. Each learns from the other to add to their particular skills and knowledge. Since so many cases are carried jointly by the pediatric resident and social worker, there is frequent consultation regarding goals, meaning of material, and information obtained from local agencies and schools. As a by-product of this joint working together, residents have become interested in visiting and learning more

about community resources. As a result of demonstration and collaboration, these physicians have developed skill in utilizing the team approach to pediatric problems. One resident remarked with some feeling that he did not know how a pediatrician in private practice could function without a social worker.

The social worker has also become involved in parent education. A comprehensive parent education program is being planned for the clinic, but in the meantime, the social worker is attempting to fill this role in part. She has available to help her in this certain pamphlets, such as those published by the Children's Bureau. She also directs the parents to other educational facilities, such as community parents' associations of retarded children.

LIAISON WITH STATE-WIDE COMMUNITY AGENCIES

Since the outpatient clinic at Riley Hospital serves the entire state, working relationships with local community agencies are an important aspect of the provision of adequate care for children. Representatives of various social agencies have observed the staff conferences to obtain a better understanding of the services provided and to facilitate working relationships. The clinic social worker has worked closely with public and parochial schools, county welfare departments, state services for crippled children, state welfare department, children's institutions, juvenile courts, public health nurses, and child guidance clinics throughout the state. Many of the referrals have been initiated by these agencies, and they represent a vital resource for continued treatment and planning.

Lay groups have also generously supported the clinic. The James Whitcomb Riley Memorial Foundation, a state-wide voluntary philanthropic foundation, has over the years given generously to Riley Hospital and has helped provide the new facilities and support the present services. The Kiwanis Club of Indiana, long

interested in Riley Hospital, provided funds to equip the new clinic.

The clinic social worker has no responsibility for establishing or collecting fees or for other financial arrangements. These are handled by the business office of the hospital. She may, however, be involved in helping the family work out satisfactory financial arrangements as part of the total medical-social planning. This may consist of helping the family apply to the appropriate agency for assistance with medical expense.

IMPROVEMENT OF PATIENT CARE

The clinic social worker has worked actively with the clinic director for improvement of patient care. For example, an appointment system has been established for all outpatient clinics. This has largely corrected some of the long waiting that is frequently associated with clinic practice. There are several investigations under way to look further into aspects of over-all patient care. In one of the large specialty clinics, the nurses are interviewing parents after their visit to determine if they understand and are able to follow through on the medical recommendations. One of the graduate nurses taking further training was particularly interested in the study of attitudes and level of information of parents in regard to the dental health of preschool age children. The clinic social worker gave consultation in the development of the structured interview form used and discussed various aspects of interviewing to assist this nurse in conducting the study.

Another phase of patient care currently being studied is that of the patient being followed in multiple clinics. Since all specialty clinics do not meet each day, a child with several disorders may have to return on succeeding days or a couple of times a week. If the family lives a long distance and the child is difficult to transport, this may create hardship. Parents also are confused by information, sometimes conflicting, given in separate clinics. In

some cases no one is responsible for integrating and relating the various medical recommendations and treatment plan of each of the specialty clinics. We are trying to determine the number of children that attend multiple clinics, what clinics are involved, and the problems that parents are experiencing. Much of this information has now been obtained and the problem more clearly determined. A tentative plan has been developed that will provide for more optimal care for these children. Other research projects in which the social worker particularly will be concerned include a study of the one-parent family, a study of the family situation in which the father has a very limited relationship with his children (tentatively termed "the phantom father syndrome"), and an investigation of learning problems. A number of other studies are in the formative stage, and social service will play an important role in their development.

SOCIAL WORK EDUCATION

The pediatric-diagnostic clinic provides an unusual opportunity for the education of social work students. The Indiana University Medical Center is a field work placement for graduate students of social work from the Indiana University Division of Social Service. Social work students have observed the daily conferences and the clinic social worker has later discussed with them the material and the questions raised in discussions. Social work students have not, as yet, been assigned cases in the pediatric-diagnostic clinic but plans are now under way for a unit of social work students to be assigned to this clinic for their second year of field work. These students will be assigned cases and supervised by the clinic social worker. In this clinic three groups of professional students—medical, nursing, and social work—will be working together in a learning situation under the supervision and direction of the full-time staff. Clinical teaching is often best accomplished by participation and demonstration. The

social work student will have a clinical experience different but also shared with the medical and nursing student. As the full-time professional staff in medicine, social work, and nursing work collaboratively in clinical practice, this professional "togetherness" will be simulated by the students. A word may be added about work in this clinic as an educational experience for the social work instructor. Opportunity to participate in the detailed discussion of diagnostic problems over a period of months provides her with a rich background of clinical information. She has an opportunity, therefore, to become more knowledgeable and grow in a professional sense.

SUMMARY

Social work has a varied and rich opportunity to contribute to and participate in expanding services for children as demonstrated in the pediatric-diagnostic clinic at Riley Hospital. Briefly these services may be summarized as: (1) direct casework services to families and children as part of a diagnostic and treatment team, (2) teaching interviewing techniques to other professional persons in training, (3) interpreting social information and knowledge of community resources to other staff working with children, (4) participation in clinical research studies that will result in better services for children and strengthening of community resources, (5) training of social work students with medical and nursing students in a practical demonstration of team collaboration.

It may be that pediatricians in private practice will develop a collaborative relationship with social work as is the practice now with many child psychiatrists. Several pediatricians could jointly utilize the consultative service of a social worker to work with patients and families who are experiencing social and emotional troubles related to medical problems in the child. The type of medical training emphasized in the pediatric-diagnostic clinic points in this direction.

BY DORIS CAMPBELL PHILLIPS

Of Plums and Thistles: The Search for Diagnosis

Simple Simon went to look
If plums grew on a thistle;
He pricked his finger very much,
Which made poor Simon whistle

APPLY MOTHER GOOSE's moral to the search for diagnosis, and you may avoid suffering the stings of reaching for diagnostic plums on thistle "trees"! For the secret of diagnosis is in knowing where to look for it. And you don't have to be so simple to make poor Simon's mistake of looking in the wrong place.

But where should you look? There are four places where the odds are in favor of your finding plums instead of thistles. The first place to look for clues to a casework diagnosis is in your spontaneous reactions to your client; another is in his reactions to you; the third is in your client's problems; and the fourth is in his proposed solution to those problems.

The obvious reason for this search—or in other words, the purpose of diagnosis—is to enable the worker and client to begin and carry through a relationship and mutual activity which help the client solve his problems. The sooner the diagnostic

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search begins, the better it serves this purpose. And the search might well begin at home.

WORKER'S REACTION TO CLIENT

To get off to a prompt start and "begin at home," the school social worker should, as she meets her clients for the first time, search out her own spontaneous reactions to the youngsters and their parents. It's a good time to do this, simply because the worker's spontaneity is not yet conditioned by her professional self-consciousness. She has not yet analyzed her client's behavior and thereby modified and objectified her own response. Her analysis, after the diagnostic search bears all its fruit, may turn out to be quite objective and nearly completely correct—a tribute to her professional ability. But before that comes about, she may well find the first of her diagnostic plums in her first subjective, spontaneous reaction.

That's because the worker's reaction is not something that wells up in her without provocation. Instead, it is elicited by the purposefulness—conscious and unconscious —of the client, whether child or grown up.

We say, rather by rote sometimes, that all behavior is purposeful. What do we mean? We mean that everything a person does, everything he is, serves his inner struggle toward balance and integration. The balance may be precarious, and integration may be knitting a cover of unhealthy defenses around a core of conflict. But, healthy or unhealthy as a personality

Search for Diagnosis

may be, its purposefulness supports the struggle for balance and integration. And so the individual brings to every relationship the purposes of his personality, projected into his behavior. He needs to have the worker and others react to him in certain ways conditioned by his upbringing, and his behavior is organized to bring forth this reaction. Even though the reaction he is bent upon bringing about may be something he fears or hates, still it confirms his inner concept of how he must behave.

Let me illustrate this point. Larry, a 9-year-old, is referred to a school social worker by his teacher, Miss Morris, about two months after school started. About one and one-half days out of every week Larry is "absolutely impossible"—he turns the classroom upside down, is wildly disobedient and leads other children into temptation, adroitly extricating himself from the situation just as the others fall into sin. The rest of the time he is thoughtful, helpful, and lovable, and Miss Morris knows of no external reasons which trigger his blow-ups.

When Larry comes to the worker's office for the first time, he enters with a swagger, smiles winningly, sits down and says, "Well, it's like this. . . ." He waves his arms expansively and pushes a pile of papers off the worker's desk onto the floor. It was an "accident," of course, but his eyes never leave the worker's face, and the smile on his lips broadens. "Oops," he says, and very slowly gets down and begins picking up each paper. There's something maddening about it, and the social worker, Mrs. Verry, who is, after all, a real person with the usual complement of vulnerable feelings, *burns*. But when he gets the papers picked up, he stacks them neatly, and steps close to Mrs. Verry. "Is that okay?" he asks, looking at her like a little kindergarten boy. He remains standing close beside her, and picks up her clock, holding it carefully and asking her if he can move the hands, how the alarm works, and so on. His shoulders, thrown back so arrogantly

when he came in, now look a bit frail, his head is bent over the clock, and his long lashes hide his eyes. His slender young figure is half-turned to her, and his sleeve touches hers. Mrs. Verry is only human. She feels drawn to this defenseless little guy, and it is with a bit of effort that she begins talking to him about why he is here. He replies to her beginning gambit with "Yes, I'm too noisy," and his innocent, respectful, wide-eyed face turned to her is so gravely concerned that she feels like saying, "Fellow, you can be as noisy as you like with me." But she doesn't say that, of course. Instead she encourages him to tell her more about that. He moves to the other side of the desk—and the spell is broken.

There he puts on an exhibit that makes Mrs. Verry feel like Miss Morris' long estranged and now reconciled blood kin. He's smart-alecky, cleverly belittling of her —maddening. Then, just as she is beginning to think that corporal punishment might not be such a bad method for social workers, Larry comes close to her, smiles his heart-tugging smile, and says, "I have to go now, but I'd like to come again. Could I come next Monday?" Mrs. Verry weakly says "Yes." She's had it.

Then, in the week that follows, this proper caseworker goes over her interviews with Larry's divorced mother, and tries to understand Larry in the light of his life experience. She becomes involved in this other kind of diagnostic thinking, and if she is not careful she overlooks the diagnostic revelation in his purposeful behavior with her.

And what did Larry's behavior, as expressed in his words and actions and in his bearing, reveal? Mrs. Verry can be fairly sure that she is not the first who has felt the stir of anger, together with the sense of closeness and identity and tenderness, when in the presence of this youngster. Why is his behavior so organized as to bring forth these reactions? That is a question to ponder upon, not in isolation, of course, but

in relation to other diagnostic intimations.

But, Mrs. Verry may say, Larry's behavior is undoubtedly handled differently by different people. And so it is. Then, how can Larry be sure he will get the same reaction from different people? Well, Larry cannot be sure of how each person will "react to his own reaction"—how he will behave when angry or when sympathetic. But it is not his purpose to bring forth identical behavior from the people who have significance for him. His purpose is to produce the closeness and then shatter it by provocation. This he accomplishes over and over. When Larry was in the third grade, his teacher nipped his classroom cutting-up in the bud. She simply drew herself up in a commanding posture, and with the authority of a dominating personality said "We'll have none of this." And when Larry drew close to her, she stared through him and ordered "Go back to work." But even this teacher had an Achilles heel. She was proud of certain science projects which had brought her recognition. Larry became a science devotee, and after a while Miss Musculatore felt very close to the boy, whose interest and accomplishments in her project elicited her identity with him, and awakened her latent motherliness. Or so it did until, on three successive demonstrations to parents and other teachers, Larry broke a test tube, spilling its contents; dropped a live frog; and knocked over a bottle of blueing. His fourth-grade teacher, Miss Morris, was a timid disciplinarian, and so it was not hard for Larry to act out his purposefulness in this area with her.

Now, of course, if a social worker is to find a diagnostic plum and not a thistle in her own reactions, she must not only be aware of her spontaneous reaction, but also be able to measure and evaluate it. That means that she must be self-knowledgeable without feeling the necessity to deny or transform what she knows about herself. With Larry, for instance, Mrs. Verry must first be aware of her anger and her feeling of identity with him. Then she must ask herself "Is there something within me that causes me to experience these emotions at this particular time, and with this particular child, something that hasn't much to do with Larry's actual presence and behavior?" Probably then she'll need to learn from others who know Larry, particularly his teacher, what their reactions are—their honest to goodness, down-to-earth reactions, which sometimes are not discovered because the teacher, too, may feel a professional obligation to present her more sophisticated insights. In summary, a Mrs. Verry should trust her own reactions, but not trust them blindly, or she may sting herself with a prickly thistle.

Before leaving this point, give some thought to one of its related aspects having to do with the school social worker's obligation to help teachers help children. If the social worker forgets the personal impact of her client's appearance and behavior, then the worker's helpfulness to teachers may be limited. For example, the first time Miss Shannon, a school social worker, sees 12-year-old Sharon's thick make-up hiding a dirty face, her shifty eyes, her hip-swinging suggestiveness, and her lying evasiveness, Miss Shannon reacts with some repulsion and uneasiness. But, almost immediately, the worker brings to bear her professional self-discipline and her professional consideration of what this means, and of why Sharon is this kind of girl. Maybe, even by the end of the first interview, Miss Shannon has lost sight of her own immediate response, and has translated the descriptive words used here into language that is less personal and more geared to cause and effect.

But the teacher, even though she, too, may have achieved some understanding of Sharon, cannot remove the girl from the group, and must cope with her in the midst of the other youngsters—not at all an easy task. For in that context, the teacher experiences the impact of Sharon's appearance and behavior day in and day out. How

Search for Diagnosis

hard it is for her to hold on to a professional attitude under the pressure of that impact! And, along the way, Miss Shannon, now almost completely innocent of even the memory of her own repulsion, loses sympathy with the teacher, so that she cannot really understand how hard it is to have Sharon in the classroom day by day. A wedge is driven between worker and teacher, which limits the worker's helpfulness.

Now let us go on to discuss the other "places" a worker may find diagnostic plums.

CLIENT'S REACTION TO WORKER

Let us say that the social worker has heeded her reaction to her client, and begun her diagnostic probe. Next, then, let us look for a diagnostic plum in the reverse: the client's reaction to the worker. And remember, his reaction to the worker begins before he ever sees her, whether we are thinking of a youngster or of each of his parents. For it begins in two paths of associations which have been formed before the worker came into the picture. One is the client's attitudes and feelings, conscious and unconscious, about the school. The other is his associations which cluster around the problems causing his referral to the worker.

Most school social workers, even those who have been in school social work for many years, think of themselves as a part of the school, and not *the school*. That's only natural. When the worker introduces herself to parents or children she has to explain her *difference* from the classroom teacher, principal, nurse, and janitor, all well-known school personnel. This encourages her to see herself as a part, a *different* part of the school, and naturally to expect parents and children to see her this way. And they do, up to a point. Some need to see her as different; others, perhaps, sense her desire to have them see her differently, and oblige. And yet, actually, to them the school social worker is not only a part but

the whole school. To the child that means the worker represents all of what school has appeared to be in his experience; to each of the parents she represents his idea of school, a concept which was born and nurtured in his experience as a pupil, and further developed by subtle cultural conditioning, and by his conscious and unconscious attitudes and feelings about his parental role in relation to the school. Remember that in this role the parent's position is conducive to some strain, for he demands from the school but also he must answer to the school; he has a measure of control, but on the other hand the school also has its control, through his child.

Earlier, two of the client's reactions which begin before the worker has come into personal contact with him were named. One has just been discussed. The other arises from his associations which cluster around the problems causing his referral. This means that he reacts to the worker as a potential helper, or perhaps as a punisher, or a derider, or a supporter, or an interloper. Whatever this reaction is, the worker's diagnostic probe will reach further if she can recognize its quality, for it has many ramifications. It tells her something about whether there is a "problem behind the problem," that is, whether the client will be too afraid, or too angry, or too dependent, or too indifferent to use her help. Finally, it will help her to see the problem itself, for if the client projects the problem on the worker, then his reaction to her becomes a reaction to his problems.

To illustrate, Mr. Ramsey, the stepfather of a 15-year-old boy, sees the worker at her request, because the boy, Donald, has become unmanageable in the classroom. The worker has already seen Mrs. Ramsey, who told her that Mr. Ramsey, whom she married two years ago, does not seem to know what to do with a 15-year-old boy. "I suppose you want to see me because you think I have something to do with the boy's trouble," he begins. And as the interview goes along he plays many variations on the

theme. Obviously, he's a bit awed by the worker, but he's irritated, too. He doesn't do much to hide his irritation as he says to her—in various ways—"You want me to be kind to Don, to give him a lot of attention, but I am not ready to do that. I don't believe in this modern stuff, about being soft and being a pal to a kid." In other words, he reacts to the worker as if she were demanding of him that he do the very things he cannot bring himself to do because they are not compatible with his own needs. The fact that he feels this demand from his wife, from the boy, and from introjected figures in his own conscience, together with his rejection of the demand, is his problem. He is, of course, projecting the problem on to the worker, and then reacting to her accordingly. Of course, she will be able to see this only if she has been engaged in a slow receptive interview, rather than a fast, suggestion-giving one. For, if she has been making the very suggestions he is fighting, then she will not know that his reaction to her is a projected one.

Now we've discussed the diagnostic clues in a client's reaction to the worker, which began before he saw her. They will continue, either conscious or unconscious, either in full-flow or ebb-tide, throughout the contact. The important point is that these reactions always bear watching in the interest of development of insight into his problems.

And, while we're talking about the client's reaction to the worker, let's remember that he also reacts to her as the person she appears to be to him, especially in his first contacts with her. He reacts to the worker as an older or younger person, man or woman, married or unmarried, better or less well-educated, richer or poorer, more passive or more active than he, more or less articulate than he, more or less "successful" in the areas he values, likable or unlikable. Not all, but some of these reactions, will show through, and they should help the worker know what it means to this person to reveal himself to her and to use her

help; especially if she carefully relates them to her other diagnostic findings.

THE CLIENT'S PROBLEMS

Let us say that the worker has noted her own reactions to her client, and his to her. Where else will she look for diagnosis? In her client's problems, of course: the problems described by the child's teacher and his parents; those the client, whether youngster or parent, tells about; those observed by the worker.

So much has been written about problems as symptoms and signs, so much has been discovered and revealed about the sources of problems and their ultimate meaning, that it would be impossible to treat the subject fully here. Instead, let us adopt a more simple diagnostic approach, which may be helpful in everyday practice. This suggests that the worker view her client's problems as *reactions,* and that she then make it her diagnostic job to figure out what these problems are reactions to, what it is in his surroundings which encourages these reactions; how well established they are in the client's personality and behavior; and finally what it would mean to him to relinquish these reactions.

Now, then, what may be the objects of the client's reactions which have turned into the problems that bring him to the worker? *First, the client may be reacting to the fact that his behavior—the kind of person he is—is not supported by the culture in which he lives, or is supported by one part of our complex culture but not by another.* Quite often, sadly enough, it is that part of our culture with which school personnel is identified which rejects the client and his behavior. Take, for instance, 13-year-old Pete with his duck-winged haircut, leather jacket, and dirty jeans, who is referred for truanting and close-mouthed, sinister-appearing defiance when he is in school. To the school he represents the feared and hated "juvenile delinquent," so much an epitome of a cast-out segment of

our society. And don't think he doesn't know it. He reads the papers, watches TV, sees the expressions on people's faces, senses the attitudes of teachers and principal. He is supported and encouraged in his behavior by the neighborhood in which he lives. But he is not living in an era when he expects to live and die in that neighborhood. Even it is changing, and Pete knows that there is no future for him there. After all, he is subject to the conforming drives in our society, and he recognizes many of the same success symbols that boys in more favored neighborhoods covet. And so, he has aspirations to find acceptance with the dominant cultural group. But these secret aspirations meet with frustration in rejection for reasons he does not fully understand, and he reacts with his problem behavior. The social worker's job is not only to recognize this, but to try to see if this boy has the capacity and the potential motivation to take the really portentous course of moving away from behavior which accords him recognition and approval in his cultural corner, to behavior that may—but he does not know it will—bring him recognition and approval in what now seems to him a hostile and rejecting corner, the enemy's corner.

Second, a client's problems may be a reaction to restrictions imposed on him by inadequacies of his person—real or imagined, genuine or self-imposed. In that case, it is not enough to know that he has a handicap. To find her diagnosis the worker will need to know specifically how the client views it, what overtones it has for him, and how others who are important to him view it. And above all, the worker should be sure she understands what handicap he is reacting to. Nine-year-old Richard cannot read, and spends his time in school and in special tutoring sessions engaged in anxious kinds of behavior, twiddling with his pencil, balancing the eraser on his head, laughing nervously when there's nothing to laugh about. The children call him "Dummy." His teacher winces, his parents

are frantic. When the worker talks with the boy about his reading problems, Richard says frankly, "I'm just dumb." But wait a minute: is that why he's anxious? If the worker is perceptive, she will notice that Richard is the only one who is *not* worried about his reading problem. And so, when the worker broadens her inquiry, she finds that what the boy is really worried about is the fact that he cannot catch a ball, although his father has sweated and cursed and shamed him in many a practice session. And the other boys won't let him play. He is convinced that he will never be a real man anyway, so why worry about a little thing like reading?

Third, the client's problems may be a reaction to his inability to relate successfully to others—parents and siblings and all the others who represent them, once or more removed. It is not possible to discuss here the intricacies of a differential diagnosis. But, if a worker thinks of her client's problems as *reactions* to disturbance in his relations with others, then she will gather the kind of information needed to make a differential diagnosis, in consultation with a psychiatrist, perhaps. For the worker will ask herself such questions as this: Is what this child reacting to immediately visible in his surroundings? Is his reaction directed to primary or secondary persons in his environment—to parents or teacher? siblings or playmates? Are his reactions oriented chiefly to the present, or to the past? Is he able to "correct" his responses as he "gets to know people better"?

Fourth, the client's problems which bring him to the worker may be a reaction to the push and pull of conflicting forces within himself. In other words, his problems may reside in the very defenses his ego has chosen to deal with its tormentors—the defenses that have been used over and over again, with a kind of "success" and, yet, are riddled with flaws which sooner or later betray him.

Let us go back to an earlier example—

to Larry. Mrs. Verry looks at the boy's purposeful behavior—the cycle in which he seeks a closeness with herself and others and then shatters it. She can readily see that this behavior is not successful in the world outside the boy. And, yet, he goes on doing the same thing over and over again. If she asks herself, "How is this behavior a reaction to the push and pull of conflicting forces within Larry? What does it 'successfully' deal with there?" then she will go on to ask "What impulsive needs and drives are involved? How does his conscience bother him? How does this behavior relieve tension for him?" But she remembers that while this behavior creates outer tension, its original purpose is to minimize unbearable inner tension between his warring parts. In looking for the answers to these questions the worker will, of course, place them in the context of all she knows about Larry and his mother.

In summary then, the social worker will be helped to find her diagnosis if she approaches her client's problems as reactions, and searches for the objects of these reactions. Having done this, and having also examined her client's reactions to her and hers to him, she will be further rewarded if she looks for diagnosis in the solutions proposed by the client, directly or indirectly, to his own problems or those of his child, and his ability or inability to use successfully his own solutions.

SOLUTIONS PROPOSED BY THE CLIENT

Rarely does a client come to a social worker without first having tried out solutions of his own. The school social worker is apt to have a double-barreled solution presented to her—the child's and the parents'—which may or may not be the same. The fact that a referral has been made is, in itself, evidence that someone is dissatisfied with the solution. It does not work for the child, or for his parents, or for other children in the classroom or on the playground, or for the teacher—one or more are sufficiently dissatisfied for the child to be considered

"in trouble." By looking closely at the solutions—both barrels—the worker can learn much about the child and his parents. The worker should ask such questions of herself as "Why was this solution chosen?"; "Why doesn't it work?"; even "Does anyone really want it to work?"; and "What does it tell about the problems it purports to solve?"

For example, 6-year-old Bobby, in the second half of the first grade, refuses to go to school in the morning, and on several occasions goes home without permission before school is over. He is direct about it: he likes school and his teacher, and he will come if his mother will bring him. His mother proposes to the school social worker that she will bring him every day for a while. That is their solution to his reluctance. But it does not solve anything, because Bobby won't go when the time comes for him to go without his mother. And the mother seems unable either to persuade or "make" him go alone—as she "makes" him do other things. Now is the time for the worker to ask questions such as those above. Then, perhaps, she will note that Bobby is not willing to give up his "solution," which he has found in forcing his mother to assure him that she really wants him to go to school. He does this through placing her in the position of parting from him instead of vice-versa. And the worker will note that Bobby's mother needs to go to the extreme of taking him every day—to protect herself from the realization that she really wants to keep him at home with her. The worker, in recognizing how the "solution" fits in with the needs of both mother and child, now has the beginning of more "why" questions, which will pave the way toward diagnosis.

What has been said is a description of a diagnostic approach, rather than a discussion of diagnostic formulations. It is meant to be helpful to the worker, who, because of the nature of things, will encounter many a thistle "tree," and may be able to make use of a few simple directions to find the real plum trees.

BY VIOLET G. BEMMELS

Seven Fighting Families

IN THE PAST decade a number of projects have been established in various parts of the country to study methods for helping multiproblem families.[1] Many of the projects report progress, change, or movement. But despite the efforts of many disciplines, some families continue to be a problem, and public and press call loudly for "results," particularly with regard to the children. The project reported here—with a tentative evaluation—grew out of a study sponsored by the Research Department of the Youth Board of New York City, and involved seven families, all but one of which had been referred by the school authorities to the Referral Units of the Youth Board because of the antisocial behavior of one or more of the children who were in school. The Referral Units had found, in their attempts to "reach out" to troubled children in high delinquency areas, that about one-third of the parents refused to accept referral to voluntary agencies, and that the families had been the clients of many agencies, both public and private, for many years. An average of seven agencies had given assistance, and in some instances the family had been known to as many as fifteen agencies.

Because of "the gravity of the situation faced by the community in attempting to check and forestall further disorganization in these multiproblem families," a City-Wide Child Welfare Committee of the Youth Board recommended that "a qualitative analysis be made of the multiproblem families to determine diagnostically what services or combination of services were called for; to determine identifiable needs according to social, health, psychological, economic, and cultural factors; how effective were the services rendered and to what proportion and to what extent were changes effected."[2] In September 1957 the writer

[1] *See* the following for general background: *Reaching the Unreached* (New York: New York City Youth Board, 1952); Alice Overton, "Serving Families Who 'Don't Want Help,'" *Social Casework*, Vol. 34, No. 7 (July 1953), pp. 304–309; *The Prevention of Dependency in Winona County, Minnesota* (New York: Community Research Associates, Inc., 1953); *The Prevention and Control of Disordered Behavior in San Mateo County, California* (New York: Community Research Associates, Inc., 1954); *The Prevention and Control of Indigent Disability in Washington County, Maryland* (New York: Community Research Associates, Inc., 1954); Charles J. Birt, "Family-centered Project of St. Paul," *Social Work*, Vol. 1, No. 4 (October 1956); Bradley Buell, Paul T. Beisser, and John M. Wedemeyer, "Reorganizing to Prevent and Control Disordered Behavior," *Mental Hygiene*, Vol. 42, No. 2 (April 1958); Kenneth Dick and Lydia J. Strnad, "The Multiproblem Family and Problems of Service," *Social Casework*, Vol. 39, No. 6 (June 1958); L. L. Geismar and Beverly Ayres, *Families in Trouble* (St. Paul, Minn.: Family-centered Project, 1958).

[2] *A Study of the Characteristics of 150 Multiproblem Families* (New York: New York City Youth Board, 1957).

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was asked to participate in a project designed to carry out these recommendations with a small group of families and thereafter met periodically with a multidiscipline team to discuss the cases.

The families were selected at random according to the following criteria: (1) failure in functioning of the mother, (2) failure in functioning of the father, (3) failure in functioning of siblings, (4) failure in marital adjustment, and (5) economic deprivation and grossly inadequate housing.

7 FAMILIES—55 PEOPLE

The seven families showed what is by now a familiar picture to social workers. Although the number of families may seem small, actually there were 55 people—39 children and 16 adults. For the most part, as individuals and as families, they displayed a common characteristic: they fought all the time. They fought with each other, they fought in school, they fought the social agencies that tried to help them. Six families were Negro, one was white. The white family was Catholic; two of the Negro families attended Protestant churches, the remaining four had no church affiliation. All the parents except one father were born in this country, with five having migrated to New York from the South in early youth. Only four of the parents had attended high school; seven did not complete grade school. They ranged in age from 29 to 64 years; the children from 1 to 21 years. Twenty-five of the 39 children were in school, 3 had left school, 11 were of preschool age. The families could all be described as lower-class.

The children. As mentioned before, all the families (with one exception) had been referred to the referral units because of the antisocial behavior of one or more school children. Of the 11 insolent and combative school children, 5 had court records. The fighting was of such a serious nature that 2 children had been hospitalized for concussion of the brain, 2 had been taken to police courts, and 1 had been suspended

from school. One adolescent girl had been hospitalized because of attempted suicide and another had threatened to commit suicide. Some of the children were characterized as being the worst problems in the school. Most of them disliked school, kept the attendance officers busy, and were insolent to teachers and principals. Sixteen of the 25 children were failing in all subjects and were poor readers. Several were nonreaders.

The parents. The parents were also unsympathetic toward the school. In many instances the school authorities had tried to win their co-operation, but the parents had either ignored the school's written requests to visit the school or were openly defiant of teachers and principals. In defending their children against the school and all authority it was obvious that they had given the children every encouragement to be combative. The father of three boys who were constantly quarreling with their teachers and classmates told his sons that he had gained respect by showing he could fight anyone. He strongly admonished them to follow his example. Most of the mothers seemed to feel they had discharged their responsibilities when they had urged their children to be always on the alert for insults and always ready to "fight back." And it must be admitted that this attitude toward fighting was reinforced by many factors outside of the home such as TV, comic strips, and the way of life of their companions.

These children were not only taught to fight but also witnessed much quarreling in the home. According to the records no parents among the seven families were happily married. In the three families of children born out of wedlock, the parent had failed to establish a close and meaningful relationship with any member of the opposite sex. In the other four families the parents quarreled violently. All but two families were the recipients of public relief, and these two earned low wages. Two mothers had been on relief all their lives,

and four generations in one family were receiving relief. They all had great difficulty in trying to manage on their relief budgets. Borrowing from food and rent budgets to buy clothing and medicine, they were constantly preoccupied in concealing their transactions from their investigators. They all expressed an intense dislike for social workers.

Living in city housing projects or tenements occupied almost exclusively by families on relief, they spent much time with others in the same predicament. It was evident that they had been caught in a "never ending cycle of dependency." With the exception of one father who earned $5,000 a year and another who believed himself to be an exceptionally gifted artist, none of the parents or adolescents had any vocational interests or goals. Work was a grim necessity to be endured or if possible to be avoided. Four of the homes were filthy and disorderly.

TECHNIQUES—PAST AND PRESENT

Since all seven families had been known to many agencies, obviously a great deal of effort as well as money had been spent in trying to help them. But they were still in trouble. It was logical to ask, then, what techniques had been used. The agency records mentioned most of the techniques and methods known to social agencies for the past half-century. Although these were usually not given in detail in all the records, mention was made of home, school, and clinic visits, referrals for medical and psychiatric attention, financial assistance, and recreation. The particular approach used depended to a certain extent on the function of the agency. For instance, home visits were usually made by Department of Welfare investigators and state hospital workers, while office or clinic appointments were given to parents and children by voluntary agencies and clinics. Referrals to other agencies and a few school visits were made by all the agencies. Although a number of appointments had been made for the clients at voluntary agencies and mental hygiene clinics, either the appointments had not been kept at all or the client had stopped going after two or three visits.

A number of social workers worked simultaneously on a case without much intercommunication, but interestingly enough there was little evidence of duplication of effort. Relief workers discussed finance and budgets; medical social workers concentrated on medical needs; family caseworkers and psychiatric social workers described the clients' difficulties extensively in terms of mental illness. There was considerable turnover among the social workers assigned. Although attention was generally focused on the mother (the father was rarely seen), the workers seemed to establish more meaningful relationships with the children than with the parents.

What obviously had occurred was specialization of function, with no one taking overall responsibility for the needs of the family. In *Unsettled Children and Their Families* Stott makes the following observation on specialization of function, which seems as applicable to social agencies as to clinical teams. He says, "Passing the child along the line from one member of the clinical team to another, each with a special function, is not only cumbersome and extravagant of professional time, but destroys the personal responsibility for the patient's welfare." [3]

Because of the complexity of urban life and the diversity of the many agencies affecting the lives of these people, it seemed highly desirable, in planning a new approach, for the responsibility to be centered on one person. The next step was to review the needs of all the members of all the families, since it was obviously impossible for one worker to divide her attention equitably among 59 people. With the focus on

[3] D. H. Stott, *Unsettled Children and Their Families* (London: University of London Press, 1956), pp. 25–26.

those in greatest need, 35 people were selected with whom the worker maintained intensive contact. Attention was focused on the mother to begin with, and the worker shared her responsibility to help the most troubled children until she was able to assume full responsibility. Home visits, school visits, and co-ordination of community resources were used, as before, but were handled by one person. These techniques were used more extensively and intensively than in previous years, however, and with responsibility for the total situation centered on one person, there was more co-ordination of community services.

This was the nub of the difference. Centering responsibility on one person actually brought about a difference in method and approach. It created a different kind of worker-client relationship—a closer relationship which frequently resulted in different diagnosis and treatment. For one thing, a closer acquaintanceship revealed that many of the clients were less deteriorated than might have been assumed at the time of referral. It is not unusual in social work records to find clients' difficulties described extensively in terms of mental illness. Because of our debt to modern psychiatry and psychology for the help they have given in understanding our clients, it is the writer's belief that perhaps we have concentrated too much on symptoms and too little on the positive traits of clients. As a result, our understanding of our clients has often been obscured by lumping them all under such broad categories as "emotionally disturbed," "guilty," "resistive to authority," and so on. The labels themselves carry so final an implication of unchanging patterns that clients are termed "poor treatment risks." The despair born of such notions is inevitably communicated to the client.

We shall review briefly, then, the work done with these families, describing the reactions to the service and the improvement that appears to have taken place over the past two years, and suggesting some ideas that have grown out of this experience of

one worker whose families were fighting, resistant, and "hopeless."

HOME VISITS

At the beginning of every case, the worker made weekly or biweekly visits in order to gain a better understanding or diagnosis of the total family situation. But the primary purpose of the home visit was to demonstrate interest in the family and to establish a meaningful relationship with all its members. Since in four of the cases there was no father, the focus was naturally on the mother. In four cases the mother would have been unable to make office visits because of the presence of small children or illness.

Owing to the anonymity and rootlessness of their lives in crowded urban areas, most of the parents were accustomed to impersonal and superficial relationships with people outside the immediate family or neighborhood. It was not easy for them to believe that they could have a meaningful relationship with a social worker. A social worker was a person who checked on eligibility for relief or took children away. They usually initiated discussions of current financial worries and avoided talking about their children at first. The worker began with the problem as the client presented it. After sharing her own problem with the worker, the client usually was ready to listen to what the worker had to say about the school problems or the afterschool activities of the children. After the initial visit, since they themselves were weak, discouraged, or cynical and felt very much alone with their troubles, all the mothers except one seemed to welcome these visits. In this friendly atmosphere they were encouraged to talk about their strengths as well as their weaknesses, their hopes as well as their fears. Positive reassurance was given whenever possible, and all signs of a desire to keep the family together were encouraged.

The objective of this process was to help the parents achieve a better understanding

of themselves and the complexities of their world as well as to inspire in them a desire for self-sufficiency and a more unselfish attitude toward their children. *An attempt was made to give meaning and direction to their lives without dominating or controlling them.* But this takes time. Stott makes the following comments on the treatment process: "In the interest of speed we cannot risk upsetting parents by too direct a cross-examination." "Growth of social attitudes and reawakening of good feelings towards people takes time." "Better attitudes towards children have to be awakened by an unhurried process of letting them realize where their true emotional interests lie." [4]

SCHOOL VISITS

Early in the case the worker also made school visits for the purpose of co-operating with school staffs. Since many of the children were in constant danger of being sent to special schools or reformatories, these visits were necessarily frequent. Many teachers seemed to find the child's behavior more tolerable with the realization that his insolence was due to the value placed on aggression in this particular milieu rather than any particular hostility felt for her as a person. Most teachers were relieved to hear the child's need described in terms of a more structured rather than a less conforming program. They all welcomed information on undiscovered abilities brought to light through the worker's use of the Stanford-Binet test. In the few instances in which the teachers remained indifferent to the child's needs, the principal agreed to transfer the child to another class rather than to another school.

Conferences were held with principals for the purpose of arousing their interest in encouraging the mothers to visit school. They issued special invitations to attend mothers' or PTA meetings. The guidance counselor acted in a liaison capacity with

the school staff and helped the adolescents with school curricula and educational problems.

CO-OPERATION WITH OTHER AGENCIES

Financial resources. Because of the material deprivation in all these families (the father earning $5,000 a year died three months after the case was opened), it was necessary to confer frequently with the relief investigator. The worker took the initiative in helping with the budgetary problem because of the atmosphere of suspicion, mistrust, and fear that existed between investigator and client in some instances, and also because of the frequent change in investigators. In some cases there were as many as four or five investigators on a particular case in one year. Although the individual investigator had some discretionary powers as far as money for clothing, carfare, and household items was concerned, the money sometimes did not arrive when it was most needed, or was not enough to meet the needs. Funds for camp clothing sometimes arrived after the camp had started. Often the child was not given money for school clothing if camp clothing had been purchased. Carfare came after the dates set for employment interviews, and the money for household items arrived after the bargains were in the hands of other purchasers. The months of delay and confusion involved in trying to bring some economic stability into the lives of these children sometimes made it necessary to find other resources. A private philanthropist was found who furnished the money needed for camp clothing, camp fees, employment fees and carfare needed for employment interviews, musical instruments, music lessons, club dues, sports equipment, some items of clothing, and tutoring in remedial reading. The largest amount of money was spent on camp fees; in all, the total amount spent on each family was not great.

Employment resources. Much time, thought, and effort were spent on trying to stimulate the employable adults and adoles-

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[4] *Ibid.,* pp. 34, 92, and elsewhere in this chapter.

cents to make an effort to obtain jobs. In several instances employers in private industry and personnel departments of institutions were contacted. Some of the adolescents were referred to the Vocational Advisory Service for testing, counseling, and guidance in obtaining employment and developing their talents. They were all advised to register with both state and private employment agencies and to follow up leads through the newspapers.

Housing facilities. Because of the unwed status of several mothers it was impossible to find better housing for some of the families in the city housing projects. These particular Negro families lived in almost uninhabitable tenements in crowded slum areas, and it was not possible to find low-cost housing in suburban areas for them.

Medical facilities. Arrangements were made through the city hospitals for medical examinations as well as for several operations. Fine co-operation was obtained from medical social service in several instances.

Recreational resources. Attempts were made to interest both boys and girls in city-wide recreational programs, the activities of settlement houses, youth centers in housing projects, and Boy Scouts, as well as the programs of the YMCA and the churches, in order that they might profit from supervised activity after school and on weekends. Since the city-wide recreation programs were usually organized on a large scale and not individualized enough to interest these children, they frequently dropped out soon after enrolling. Some of them enjoyed swimming in the pool at the YMCA and seemed to profit from the Boy Scout activities. Several churches seemed better organized to meet the individual social needs of these children. The worker organized some group activities with the help of neighbors, relatives, and the children themselves. The children seemed to profit most from those activities they helped to create. A great effort was also made to send fourteen children to summer camp for a month, since it was felt that summer camp could provide a fine opportunity to build up different values and standards.

CLIENTS' REACTIONS TO SERVICES

In all seven cases there seems to have been a trend toward improvement on the part of both parents and children. They are no longer solely preoccupied with fighting. Encouraging their children to study and obey their teachers, these parents no longer identify with the children against all authority. Some of the mothers have gained insight into the effects of their favoritism, overindulgence, and negligence. Most of them have made an effort to create more orderly homes. Occupied with homemaking activities, PTA meetings, church activities, and summer camp programs, they are gradually becoming less preoccupied with their grievances against the public relief system. They are showing an increased interest in the education of their children, supervise their homework and visit school. Several parents and adolescents have developed an interest in becoming self-supporting. Two fathers who had not worked for years obtained employment. One mother is studying beauty culture with the hope of becoming financially independent as soon as her children are older. Two adolescents, a brother and sister who had formerly made little or no effort to find work, have been working for the past year. The sister is working in a factory and attending a beauty culture school in the evening. The brother was recently promoted to the job of supervisor.

Improvement was shown in the following children's problems:

Problem	No. of children at time of referral	No. of children at present
Insolence and fighting	11	2
Poor school work	16	5
Truancy	7	0
Stealing	4	0
Suicidal attempts	2	0
Fearful, withdrawn behavior	7	5

There has been lack of progress with some individuals as the table shows. Two boys—brothers—are still fighting; but they are in difficulty less frequently. Because of their father's death, the selfishness of their relatives, and the lack of co-ordination of agency efforts, these boys have been subjected to unusual stress and strain. Four of the children described as fearful, withdrawn, and showing no improvement come from one family whose dominating parents exercise rigid control. Since the initial efforts to "reach out" to these parents were not used constructively, weekly home visits were terminated, but the worker remained active in helping the public relief agency to verify the father's earnings. This family had hidden the father's intermittent employment as a painter for twelve years, and had received full relief checks during that time. Now, however, they are living on the father's earnings with a small supplement from the agency. In addition, since it is no longer necessary to hide their financial status from the worker, it is to be hoped that a relationship can be developed with the parents which will enable the worker to be more helpful to the children.

The other withdrawn boy comes from a family where he was overindulged. He is a dull normal adolescent who learned little at school and is now making little effort to find employment. It should be added that he is withdrawn only in relation to school and employment. Although quiet and shy, he is sought after by his own group and seems to be leading an active social life. Another adolescent boy who has a fine voice is attempting unsuccessfully to "get rich quick" by making rock'n'roll records. After the police found a knife in his pocket one night while he was walking down the street with friends, he might have served a jail sentence if his aunt and the social worker had not come to his rescue in finding employment and a musical scholarship for him. He failed to take advantage of the opportunity to train his voice, saying that he preferred rock'n'roll. He also gave up his job in a few weeks.

CONCLUSIONS

After two years of work on four cases and eighteen months on the three other cases it must be admitted that any statements made at this time on diagnosis, treatment, and results cannot be regarded as conclusive. But since a number of agencies working with multiproblem families have recently found these families responsive and capable of improvement, it seems timely to add these observations to other reports. As far as diagnosis is concerned, after close contact it appeared that some of the parents were not as deteriorated as one might have thought at the time of referral. With emphasis on existing positive traits, and sometimes just on the *possibility* of positive traits, the parents seemed able to accept and identify with the worker's attitude toward fighting, insolence, and laziness.

The question has been raised as to whether the basic structure of the personalities has been changed, and also whether a lasting change has occurred. The word "basic" can obviously be defined in many ways. A cessation of hostilities and greater self-reliance can certainly be regarded as bringing about important changes in the lives of troubled people. In this project it can be said that nine children stopped fighting, while several parents obtained employment and have seemed more capable of carrying out their parental responsibilities. It is impossible, however, to predict how long these changes will last. Three of the seven families are taking such a responsible attitude at the present time that it seems possible for them to function without further assistance. Transfer of the remaining families to other agencies will make it necessary for other workers to spend much time, effort, and money in getting acquainted. And with a difference in relationships, objectives, and methods the results might be quite different.

The question is also asked: can the community afford to support a program involving the continuous relationship of one worker with multiproblem families over such a long time? Another question might be posed in reply, namely: can the community continue to support programs involving so many short-term workers over so long a time? The process of becoming acquainted and understanding these multiproblem families is so time-consuming and laborious that it should not be repeated over and over again. To quote the psychiatrist on the multidiscipline team of this project, "We have merely scratched the surface."

Many people, including social workers, insist that the kind of intensive work with a few cases here is "unrealistic" and "impractical." They will say there are neither funds nor workers available for such a program. Pressed for alternatives they are apt to fall back on the need for special schools, institutions, and psychotherapy. But special schools and institutions are also expensive, and since social workers often find graduates of institutions and foster homes continuing to lead troubled lives as adults, improvement in many institutions and foster homes seems indicated before they can be thought of as offering a major solution. Psychotherapy is not only expensive but probably inappropriate for many of these cases.

In view of the complexity of the total situation and the futility of trying to oversimplify it by looking for one cause and one cure, it seems more realistic to approach the problem from many angles. If teachers could be persuaded that many children with "family problems" can be helped tremendously by a good, positive relationship with their teachers, and that many deprived children can find great comfort and satisfaction in achievement in school, since they have no little opportunity for achievement at home; if public welfare programs could be reorganized so that investigators would have fewer clients and thus be given an opportunity to think of

their clients more as individuals and less as categories; if government employment agencies, employers in industry, and relief workers could work more closely together to provide suitable employment for many of the unemployed; if church workers would make more of an effort to reach out to the "disinherited of the earth"; and, last but not least, if we would all think less about "selected case loads" and see the value of bringing about much needed environmental changes—if we could do these things, then the number of multiproblem families might decrease to such an extent that communities could finance and find the workers for the intensive kind of program the few remaining families would continue to need.

HELPING JUST ONE CLIENT

We have become intoxicated with numbers. As long as little value is placed on helping just one individual, reducing the number of children in classes or the number of clients in a case load will not automatically bring about better results. Attempts to reconstruct educational and welfare systems will have to be preceded by a change in philosophy if the change is to be effective. When faced with the effort required to help just one individual in a multiproblem family, people often say, "But that's just a drop in the bucket. Isn't it unrealistic to put so much effort into helping one person when there are 20,000 multiproblem families in New York City?"

Perhaps the answer is that not all multiproblem families are like these seven families whom so many agencies failed to reach, since a large proportion of the problems of the 20,000 families are neither so deep nor so intense. The intensity of work with this group was the result of intensity of need. Confronted with the problem in all its detail, too many teachers and social workers shy away from it, convinced that the only way to be "successful" is to become concerned with the over-all problem—to think as administrators—to become administrators. They fail to real-

ize the meaning and value they have for each individual whom they teach or help; they minimize their influence and the importance of their efforts.

Without question, changes are needed in the outer circumstances as well as the inner lives of these multiproblem families before any lasting change or widespread improvement can be expected. Specifically, we must work vigorously for slum clearance in urban areas and more adequate relief for mothers willing and able to stay home and give their children the kind of responsible care and supervision they need. We must create more individualized and better supervised afterschool, weekend, and summer programs for troubled children in urban areas.

Professor Stott says, "Social workers have an influence and responsibility that goes beyond the individual case. They need to work against the tide of faulty tradition or contemporary fashion." [5] He indicates that we should be courageous enough to ques-

tion past and current values if we are to carry out our responsibilities. We might begin by thinking about the overemphasis on socialization and being popular that exists in every kind of neighborhood and question the emphasis placed on a good social adjustment as a primary goal for our clients. We might also question the value of giving relief on a large-scale, impersonal basis and ask whether the client does not often become more dependent or rebellious under the present system. These and many other questions will undoubtedly have to be raised and answered before the problem of the increase in delinquency, mental illness, and dependency can be solved in this country.

But if teachers could hear themselves quoted as often as this worker hears them quoted—if they could hear that "hopelessly incorrigible little boy" in the back seat saying, "My teacher says . . ."—they might place a different value on their efforts and so create a different world. And the same is true for all other professionals who touch his life.

[5] *Ibid.*, p. 77.

BY JACK A. DAVIS

Emotional Problems of Service Families Living in Japan

A COMMON EXPERIENCE for a service family of today is a tour of duty overseas. The stimulation of travel—contact with a different culture and a different community— can be a rewarding and worth-while experience for the family. It does involve, however, some emotional hazards as evidenced by those seen in any dispensary, chaplain's office, or other facility overseas where people in trouble take their problems. The battery of injections given any person going abroad with a service organization may do much to prevent physical disease, but the emotional problems experienced by the military man and his dependents are less easy to prevent or predict. There is much less awareness of emotional hazards on the part of all concerned.

It should be noted that, with industrial and diplomatic developments multiplying in complexity throughout the world, increasing numbers of Americans other than the military are taking tours of duty in foreign lands for extended periods of time. The husband may represent an American company, or may have a position with the American government, or under a govern-

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ment program. This paper will attempt to describe some of the problems that present themselves in a military psychiatric clinic in Japan. Although unique in some ways, they bear similarities to the experiences of any group of people away from home and in a foreign land.

In leaving the United States and coming to Japan, all members of a family find many of their normal functions and relationships disrupted or having to be modified. Relatives, friends, former home, church, school, and club are left behind. There are frustrations in travel, but even more important are the unknowns of future living arrangements such as housing, schools, medical care, clothing, and the assignment of the husband.

HOUSING

Housing becomes a major problem for many service families from the day of arrival in Japan. The service is unable to provide quarters on military installations for most families immediately upon arrival; the serviceman, prior to leaving the United States, agrees to live on the economy of Japan when it comes to housing. The family may have to wait months or a year or two for government quarters. A Japanese house is small by American standards and not well insulated from heat and cold.

Service Families in Japan

There is little in the way of yard space. When it rains, the outside area is usually a mass of mud, and many roads traveled back and forth to and from the base would be considered impassable by American standards. The family may be isolated from other American families or have only a few Americans in the vicinity. When the plumbing breaks down or the stove doesn't work, an inexperienced family does not know where to turn for assistance. The telephone lines are operated by Japanese-speaking operators and cost several hundred dollars for installation. The physical isolation of all this is minor compared with the psychological isolation experienced by many. The feeling of being thousands of miles from home, of living in the midst of strange people who cannot communicate in the same language, who eat different food, who have different tastes and think differently, may result in loneliness and depression if there are not other, compensating factors.

THE SERVICEMAN AND HIS WIFE

An overseas tour is usually less emotionally demanding on the serviceman than on his wife. He often has his assignment determined for him prior to coming abroad. Reporting for duty and working in an atmosphere that is familiar to him are reassuring. He soon gains the satisfactions that come from performing tasks and knowing that his services are needed. His assignment establishes a routine for hours of work which keeps him occupied for a major portion of his working hours. While at work, he makes friends with those who have a background of experience similar to his own. The service itself is a major source of security for most servicemen.

The wife experiences greater demands and may have much more to accomplish in the way of adjustment while living overseas. The security and satisfaction that her husband derives from his assignment touch her only indirectly. The loss of former friends, relatives, and social interests may be replaced by other friends and interests in time. During the initial period of getting established, there is often the feeling of isolation and frustration in trying to set up a satisfying and workable way of living for herself and the family. She may become even more dependent on her relationship to her husband when other friends and resources are not available. This may result in an increase in family unity, where feeling is easily communicated and the family members are flexible enough to adjust to the changes. On the other hand, problems often develop when overly dependent wives are unable to accept the limitations and frustrations, and the husband is unable to accept added responsibility and give emotional support under the circumstances. The husband may have difficulty while at work and feel unable to accept additional stress at home. He may feel helpless about a difficult home situation and partially withdraw from it by added hours of work which can be easily justified in his own mind. A more overt withdrawal from difficult home situations is that of the serviceman who finds an outlet with other service friends in drinking, or in affairs with Japanese girls. Alcoholic beverages are inexpensive in Japan, and drugs more easily obtained than in the United States. The social controls of American society are less in evidence. Some servicemen feel socially unacceptable behavior condoned or even approved of in a foreign land where they have no close ties with the foreign population.

When travel facilities are limited and military facilities overseas pushed to capacity, the serviceman often precedes the other members of the family by several months. This is an additional hardship for many families. The wife remains at the former home and must make the necessary preparations alone, such as getting passports and medical injections, making plans for the storage and shipment of furniture, and so on. With small children, these tasks

are magnified many times. The wife is less secure in traveling across country, waiting at the port of embarkation, and moving by ship or plane—particularly with small children—when the husband is not present. When there is separation for a period of months, the equilibrium within the family unit rearranges itself. The wife makes the decisions, disciplines the children herself, and handles the financial affairs. Joining the serviceman overseas precipitates another rearrangement of these interacting forces within the family. It cannot be simple restoration to the normal pattern, since it occurs in quite new circumstances, which affect it. Along with the frustrations of adjusting to other factors involved in overseas living, the first months are often a trying time within the family for both adults and children.

The arrival of the family overseas may also involve a rearrangement in social interests. In the period before his wife can join him, the serviceman often becomes settled in military quarters for men without family.

> Sgt. B got along with his family while in the United States. He went overseas ten months prior to the arrival of his wife and three small children. During the period away from his family, he went out with other men in his barracks. Even though he missed his family, he enjoyed the close association with the younger unmarried men who had few responsibilities. Following the arrival of his family he wished to continue "nights out with the boys" and resented his wife's disapproval of this behavior. She felt hurt and at the same time suspicious of what had been going on prior to the family's arrival. The readjustment required that he accept responsibilities, and he did so reluctantly. In time, they were able to develop mutual friends and social outlets which were more satisfying to both.

Many of the wives who develop anxiety or become depressed lack the qualities of personality either to communicate more effectively with their husbands or to relate themselves to others in the more limited foreign community. Often the wife has one or more small children and may be pregnant. She may not know how to drive; in any case the husband probably needs the car to go to and from his work. Bus service is usually not available.

> Mrs. B, age 25, is the wife of a staff sergeant. One month after her arrival in the Far East, she was referred to the psychiatric clinic because of crying spells, feelings of dejection, poor appetite, and difficulty in sleeping. She was living in a small, four-room, Japanese-style house in a compound with nine other American families. Their kerosene stove had blown up twice; she had difficulty in keeping the house warm and trouble in getting a Japanese workman to correct the defects in the stove. Her husband worked in a unit which was classified for security reasons so that he could not discuss his work with her. She had three children, ages 4, 2, and 1, who were constantly under her feet, resulting in irritation toward them toward the end of the day. She felt isolated being alone with the children all day while her husband was at work with the family car. She had not been successful in making friends in the immediate neighborhood. Her husband could not understand why she felt unhappy and tended to remain quiet during the evening when he was with the family.

Additional pressures such as illness back home, illness of the wife or family, financial problems, or legal involvement with the Japanese for such things as traffic violation may be added burdens which push the wife to the breaking point. Other contributing factors may include periods of separation from the husband while he is away on temporary duty, perhaps for weeks or months at a time. Shopping, caring for sick children, having a baby, and coping with other emergencies while the husband is away on an indefinite military assignment may bring to the breaking point a woman whose frustration tolerance has already reached its limit.

Service Families in Japan

Domestic help is inexpensive in Japan; many families who could not afford to do so in the United States have a maid there. Although this may free the wife to engage in social activities she was formerly not able to enjoy, it may also result in additional time which she does not know how to use constructively. With her housework done for her, she may feel more useless—less needed. If she has worked outside the home prior to coming overseas, she may find no opportunity in her field of work, since Japanese women fill many of the positions for women both in the military and in the civilian economy.

Mrs. C is the 36-year-old wife of a captain, married for sixteen years. Prior to coming overseas, she was busy with her household duties and had only the usual domestic difficulties. After her arrival she engaged a Japanese maid for the equivalent of about $28 a month. The maid took over most of the household duties. Mrs. C soon found more time on her hands than she knew how to use. She felt bored, but did not pick up on the wives' activities and classes that occupy many wives in these circumstances. She met a few friends who liked to drink, and soon she was involved in a round of parties both during the day and at night. She felt accepted by the group and often drank more to be sociable than for any other reason. Her husband soon objected and accused her of being a poor wife and mother. Her reaction was to withdraw from her husband and to depend more on the circle of friends. She would be lonely and depressed on some days, and looked for a drink to help her through the day. Eventually she was referred for psychiatric help.

PREVENTIVE SERVICES

Social resources which are found in almost all American communities are not available to the service family. When difficulties arise, a service family overseas cannot look to the traditional health clinics, marriage counselors, and child guidance clinics that civilians find. The family is dependent almost entirely on the resources provided either directly or indirectly by the armed forces. As a result, the role of the chaplain, the commanding officer, the physician, the recreational director, and the Red Cross worker as counselor takes on more significance in the overseas setting than it normally does in the United States.

The services have come to recognize many of the concomitant problems for overseas families and have been active in developing programs to counteract many of the frustrations and limitations that prevail. Morale is recognized as the responsibility of the commanding officer, and a portion of his time is devoted to programs which will foster good mental health.

One provision that is made to help orient new families is the appointment of a sponsor, a fellow serviceman already living in Japan who has approximately the same rank and is from the same military unit as the new serviceman. The sponsor corresponds with the serviceman prior to his coming overseas and in this way helps the family both materially and emotionally for the overseas experience. He meets the plane or ship that brings the family, arranges for temporary housing, and goes with them to be introduced to the serviceman's new unit. The sponsor is temporarily relieved from duty while he helps the family to find housing and arrange for fuel, water, furniture, and other essentials. An organization known as "Family Service" has been established at most military installations, staffed largely by volunteers who are interested in helping other families to work out their problems. One of its primary functions is to help new families establish themselves. Family Service units usually have blankets, cots, stoves, dishes, and other essential items which can be lent on a temporary basis to newly arrived families.

Orientation lectures are given to both serviceman and wife by specialists in various fields, such as personnel, legal, and medical, as well as areas under the chaplain and

provost marshal. Servicemen are also oriented to their unit by the commanding officer or one of his representatives. Service clubs, including wives' clubs, commissary, service stores, and recreation facilities, are readily available.

Chaplains' programs not only offer their services in the way of worship programs and group activities but have also provided individual counseling. Some chaplains' programs have included a personal visit to each new family shortly after arrival.

In the course of a move across country and overseas, many families find that travel expenses are greater than anticipated. They usually need to stay in a hotel or guest house on arrival prior to securing housing. The serviceman is helped to meet this added financial burden by travel allowances and by advanced pay if necessary. Occasionally, a serviceman or his wife may need to return to the United States because of a death or severe illness back home. The American Red Cross and organizations such as the Air Force Relief Association may provide financial assistance in case of emergency. The commanding officer also may be a resource in case of financial difficulties, since he may help the serviceman in budgeting his income and in making allowance for advance pay in some emergencies.

Medical facilities are acquainted with those who are experiencing unusual emotional problems. The medical officer does much to help support those with numerous symptoms which are obviously of psychogenic origin. Some are referred for evaluation and care to a psychiatric clinic. For severe cases, the solution may be a return to the United States. Most patients can be helped by short-term outpatient care to adjust better to the situations in which they find themselves. The psychiatric social worker is by training and interests fitted to work with many who need help as a result of environmental and emotional stresses.

Emphasis is placed on supportive help with work toward clarification of some of the contributing factors in the person's situation. Help is given the patient to establish better communication, particularly with the husband. Seeing a husband once or twice is a positive step toward helping him to understand his wife's behavior and to modify his attitude toward her. The patient is supported in moving toward interest in social, religious, and volunteer organizations that will stimulate more healthy outlets for pent-up feelings. Treatment often involves helping to re-establish a family equilibrium that has been upset by the changes involved in coming overseas.

Some outpatients who are less able to form relationships, either inside or outside the home, benefit from participation in group therapy. The patient soon becomes aware that many others are experiencing symptoms similar to his own and that the environmental pressures have to be coped with to a greater or lesser degree by all families coming to Japan. The feelings of isolation diminish when there is an exchange of feeling and some group solidarity is experienced with the discussion group.

Military social workers in the Air Force are confined to the Psychiatric Service of the medical program. Through consultations from other hospital services, they usually work with patients from all services within the hospital. The Army Social Work Program includes both psychiatric and medical social work. The Navy has no military social workers, but uses some civilian social workers in its medical program.

Turning for a moment to the question of nonmilitary groups away from home, it may be noted that representatives sent to foreign lands, whether by industry, under government programs, or in still other connections, are usually key people who have been successful in their own fields. Their feelings of competence and satisfaction in their work usually produce ample fulfillment for adequate living. Such representatives are generally well paid. Often the problems of providing material necessities such as

housing, food, and clothing have had some attention. However, the emotional problems involved in dealing with a foreign people outside of working hours, and providing security and satisfying outlets for wives and children, have received less attention. Those who are to furnish medical care and recreation facilities for groups living in foreign countries must increasingly study the problems discussed in this paper in order to combat isolation, boredom, homesickness, and the feelings of apathy of people away from their native land.

Both social casework and group work services have much to offer those in need of these preventive aspects of mental hygiene. Community organization directed toward better mental hygiene for those serving in a foreign country has scarcely scratched the surface.

SUMMARY

Service personnel have long been aware of some of the physical hardships and hazards as well as the opportunities involved in overseas tours of duty. The means for helping overseas personnel meet the emotional problems of living in a foreign land have scarcely kept pace with the problems presented. Most families experience feelings of isolation, helplessness, and unusual frustration; but most well-integrated families are likewise able to work through their feelings without too many complications. However, families who have previously made only a marginal adjustment, or who carry additional burdens resulting from marital discord, illness, debts, death back home, or unusual circumstances related to the husband's military assignment, are likely to become problems. The service recognizes the need for good morale in servicemen and their dependents. Much has been done to foster good mental health, but there is room for much more. Social work is making its contribution to mental hygiene in the military, largely through psychiatric and medical programs; it can offer much more in the future if used on a broader basis.

The "Special" in Specialization

As a SOCIAL caseworker with considerable experience in a family agency of high standards as a caseworker, supervisor, and district administrator, I have been curious about the differences in skill and in responsibility of the psychiatric social worker as compared to the family agency worker. This interest increased during the period of discussions when the National Association of Social Workers was formed after years of efforts in that direction, and when some of the Sections preserved their identity according to special settings within which social caseworkers were functioning.

In civil service little of my experience would be credited toward eligibility for taking examinations in psychiatric social work classifications. Obviously, then, at least the Psychiatric Social Work Section of NASW as well as those responsible for working out civil service standards consider the work, skill, and responsibilities of the psychiatric social worker to be quite different from those of the family agency caseworker. (In my position I can only speak for family agency workers, but assume the same may be true for the child welfare worker.) Thus, when I found an opportunity to use ten weeks of sabbatical leave to gain some experience in a psychiatric setting, I attempted to learn more about the specialization of the psychiatric social worker.

I visited a new institution serving the three main functions of treating the emotionally ill, training therapists and nurses, and doing research toward the end of finding more and better ways of healing. I was invited to observe and participate in various programs of the hospital. In consultation with the chief psychiatric social workers and some of the medical and the psychological chiefs, I was able to plan a program covering my main interests.

In the Children's Unit I read the records of psychotic inpatients and their families who were also receiving treatment. I was able to observe therapeutic hours of these children through the one-way screen, and to discuss the cases with the therapist. In the same department I sat with and observed groups of children in the dining room. Together with staff members I attended intake conferences and treatment conferences on inpatients as well as outpatients. Only few of these came up during the summer months. I participated in a few sessions of the continuing case seminar, led by one of the psychoanalysts for the social workers of the Children's Unit. I took some applications for inpatient as well as outpatient treatment in this unit, and following the usual procedure I had to present these cases in application conferences with the department heads. The plan of carrying a case through the diagnostic study could not be worked out because of the limited period of time available.

In the Adult Unit, I attended diagnostic and disposition staff meetings of the Inpatient Department regularly. I also attended weekly ward rounds with the acting medical director, and consultations of this department with the chief of inpatient care of the Children's Unit in relation to some adolescents hospitalized in the Adult Department. In the Outpatient Department I was invited to participate in the weekly meetings of one of the regular teams, also to sit in on some special consultations with a visiting psychoanalyst. At my own request, I was also invited to observe regularly through the one-way screen the two outpatient therapy groups. I also participated in the weekly staff discussions of these groups.

In evaluating this experience, one needs to keep in mind that neither my profes-

sional training nor my professional experience included any experience in either a medical or a hospital setting. However, the family agency worker accumulates much and varied experience in working jointly with general medical as well as with psychiatric agencies, inpatient as well as outpatient departments. In addition to joint case conferences, referrals are made back and forth, and in order to serve his clients well the family agency worker needs to be thoroughly familiar with the functions and with some of the procedures of these other treatment resources. I have not found important differences in either knowledge or skill between the social caseworkers of my home agency and those of the hospital I visited. "Social casework is the professional method employed by a caseworker with an individual who needs help with some aspect or aspects of social functioning." [1] The same skills are used in making a diagnostic study, in formulating a diagnosis and a treatment plan, in using appropriate techniques in either the supportive treatment method or the modifying treatment method. Depending on their professional background some of the psychiatric social workers had less knowledge of the community and its resources than a family agency worker is expected to have. On the other hand, depending on their professional background, some of the family agency workers lack the experience of observing psychotic children or adults in a hospital setting. To me, it seems, I have learned considerably from being able to observe (in a sense) the mentally ill person from young childhood through adolescence into adulthood. This additional knowledge will benefit those I serve. This experience of course was derived from visiting all departments of the hospital, which no social worker employed there has had this over-all opportunity.

The one difference in approaching the patient's or client's treatment which is stressed in the literature is of course the approach by a team of representatives of different disciplines.[2] From my viewpoint, this can be learned equally easily and rapidly as any procedure in a setting new to an employee. Even within this hospital the team approach differed with different departments and with different individuals. Noteworthy was the atmosphere of ease in staff relations, a freedom to pursue special interests, an opportunity to study, learn, and test thoughts and opinions during the coffee break, over the lunch table, in conference.

Teamwork on various cases makes for free interdisciplinary exchange of thinking and feeling. This is experienced as stimulating and as relieving. It also makes for the sharing of responsibility on any one case as compared to the full responsibility the family agency worker carries and feels for the clients and their families (except in those few instances where several caseworkers are assigned to one family). This is particularly true in relation to diagnostically unclear borderline cases where the psychiatric social worker derives support from the involvement of the medical profession and the availability of medical prescriptions if indicated. The definite selectivity of cases at the point of application, the clear-cut psychotherapeutic focus establishes more easily the limits of the therapists' responsibilities toward the patient and toward the community. As a result of the "open-door policy" traditional with family agencies and expected by the community, the family agency worker tends to be all things to all people and often suffers in carrying this burden. The extreme illustration might be that of the family agency's work with the hard-to-reach, hard-core family.

Some experience additional to that within one's home agency is desirable. Only a training institution can allow for as broad an experience as I have had. Only a pro-

[1] Community Service Society of New York, *Method and Process in Social Casework:* Report of a Staff Committee (New York: Family Service Association of America, 1958).

[2] Ruth I. Knee, ed., *Better Social Services for Mentally Ill Patients* (New York: American Association of Psychiatric Social Workers, 1955).

fessionally experienced person will be able to derive the same benefits from this kind of a visit. This is where my "visit" differed considerably from field placement during student years. The adjustment to working in a psychiatric setting after experience in a family agency is no different from that in any new agency. I have not been able to discover any difference in the basic knowledge or skill of the psychiatric social worker and that of the family agency worker. The psychiatric hospital lends itself naturally to the promotion of self-reliance and to the independent use of a variety of sources for learning.

The psychiatric profession is developing a growing interest in reaching out to those not voluntarily seeking help, and in working with families instead of considering individuals alone. Might one speculate on a future family agency where psychiatrists and psychologists work in teams with the social work staff in an effort to treat and prevent family ills?   LUCIE MAYER

Impact of the Curriculum Study

DURING 1960, THE attention of the whole field of social work will be directed toward the thirteen volumes of the Curriculum Study published by the Council on Social Work Education. In the last issue's editorial (SOCIAL WORK, October 1959), Gordon Hamilton makes reference to the reminder that social workers "must have courage not to be frightened by new and different ideas and . . . must have disciplined minds to examine the most radical findings without prejudice." Without doubt, the study will be the subject of careful analysis and deliberation by faculties of schools of social work and undergraduate programs. It should also be scrutinized closely by members of the National Association of Social Workers and others concerned with advancing the goals of social welfare. NASW's national Commission on Social Work Education has been in touch with this study and on the basis of its own review of the thirteen volumes has prepared a short study guide for NASW chapters in assessing the findings and recommendations.

It is impossible at this time to visualize fully what impact these reports will exert on social work education and practice. The study is clear in its recommendations with reference to reorganization of the social work curriculum. The postulate which forms the main thesis of the total study suggests that the objectives sought in the system of social work education can best be achieved when viewed as a continuum extending from the undergraduate through the graduate years of education. It should be strongly emphasized that the findings themselves do not in any way suggest a rigid blueprint for the restructuring of social work curriculum. The issues are set forth for the purpose of permitting a critical inspection of the present program of education for the field of social work. It would be well for all to remember that the program of social work education is in the hands of

educators and functions within the framework of higher education in the United States. Any debate on restructuring social work educational content which proposes in any way to affect undergraduate education must, without question, then extend itself to the very serious issue of the degree to which liberal undergraduate education will be influenced by professionally oriented content. This is an issue which is not easily understood and which is likely to promote continued and bitter debate. Two powerful arguments for a structuring of curriculum to provide relevant content at the undergraduate level can be summed up in the following two words: recruitment and manpower. These two matters are of urgent concern to both educators and practitioners. Neither, however, would wish to do violence to the conception of professional education as a circumscribed and clearly defined area of educational effort which does, in fact, prepare people for practice in the social work profession.

It is the point of view of this writer that any "freezing" of educational patterns would be most unwise and that considered judgment of the implications of variations in content and shifts in focus should precede curriculum changes. This implies a hard look at the study findings and a degree of objectivity that will test the profession's ability to discern and assess the long-range implications of the recommendations. It is not likely that any decisive action will be taken to vitiate the two-year framework for professional education for social work. Nor is it likely that the social work profession will abrogate its vital concern and responsibility to provide for adequate staffing of welfare services at all levels.

It behooves every social worker to inform himself of the content of the Curriculum Study and to develop his own opinion of the practicality of the recommendations. The Council on Social Work Education has wisely taken the position that the study should be viewed as offering very general recommendations for the use of the schools.

It is clear that any changes which may come about will probably result from evolution rather than revolution. An informed social work public can contribute to this evolutionary process.

MILTON WITTMAN
Chairman
NASW Commission on
Social Work Education

Group Screening of Parents

FOUR YEARS AGO, the Child Guidance Clinic of Jacksonville, Florida, initiated group screening of parents in order to render immediate service to applicants and to identify and eliminate potential nonattenders. It was noted that at least one-third of the applicants did not arrive for their initial appointment, and that a number of people who attended the meeting failed to return the completed medical form, thus terminating their contact with the clinic.

A study sponsored by the Bureau of Maternal and Child Health of the Florida State Board of Health was made to establish answers to the following questions: (1) What accounts for nonattendance after an appointment is accepted by the parents? (2) What accounts for the failure of some parents to carry out the next step in the intake procedure, namely, returning the completed medical form? [1]

Two hundred parents who failed to keep their initial group appointment and 100 parents who failed to return medical forms after attending the meeting were contacted by telephone and asked to state their reasons for terminating contact with the clinic. The two hypotheses of the study predicted that (1) a negligible number of parents who failed the initial appointment did so because of reluctance to attend a group meeting per se; (2) a negligible number of parents who failed to return the medical forms after attending the meeting did so because

[1] Haim G. Ginott, "Preintake Selection of Motivated Applicants in a Community Clinic," *Social Work*, Vol. 4, No. 2, (April 1959), p. 105.

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of negative attitudes toward the group procedure per se.

Both hypotheses were supported by the study. Only 1 percent of the parents who failed to attend the initial group meeting, and only 3 percent of those who failed to return the medical form attributed their withdrawal from the clinic to negative attitudes toward procedures. Other reasons given for missing the initial interview or for failing to return the medical form are included in the following lists.

Reasons for missing the initial interview

	Percent
Difficulties in getting to the clinic	23.5
Parents' attitude toward problem changed	21
Problem alleviated	20
Received help from other sources	15
Forgot time of appointment, forgot reasons for not going, etc.	12
Child or husband objected to clinic referral	5.5
Advised child had no need for clinic services	2
Reluctant to attend group meeting	1
	100.0

Reasons for failing to return medical form

	Percent
Parents' attitude toward problem changed	23
Problem alleviated	19
Received help from other sources	17
Difficulties in getting to clinic	14
Vague reasons	9
Advised child had no need for clinic services	7
Could not afford medical examination	4
Child refused to come to clinic	4
Negative attitude toward group procedures	3
	100.0

The main conclusion of the study is that, based on reported attitudes, the preintake procedures described in the preliminary report published in this journal are effective means of identifying and eliminating a large proportion of potential nonattenders. The full study is reported elsewhere.[2]

Child Guidance Clinic   HAIM G. GINOTT
Jacksonville, Florida

[2] Haim G. Ginott, Libby Blek, and Ruby I. Barnes, "A Study of Nonattendance of Initial Interviews in a Community Clinic," *International Journal of Group Psychotherapy*, Vol. 9, No. 3 (July 1959), pp. 314–321.

The Little Fish Eat Mud

"The big fish eat the little fish and the little fish eat mud." This dour line is found on page 233 in Albee's chapter on "The Crisis in Education," in *Mental Health Manpower Trends,* (George W. Albee, Basic Books, 1959). It applies in context to the tendency of the wealthier universities to draw faculty from other educational institutions who in turn raid the smaller schools, but its pessimistic theme could be used to describe the situation in mental health manpower today. In brief, this book tells us that there are insufficient numbers of mental health personnel for the existing tasks; there are too few being trained to meet known needs which grow with the expanding population; the wealthier, more urban states have more of the manpower. Moreover, there are certain basic deficiencies in relevant supporting fields which make the outlook even dimmer. There are no ultimate solutions proposed in this report either for the little fish or for mental health manpower.

The complex dimensions of the problem of personnel supply and demand have been ably explored and presented in this third report of eleven to be published by the Joint Commission on Mental Illness and Health as part of its comprehensive analysis of the mental health problem in the United States. While there was no attempt to assemble primary data, this volume provides an integration and evaluation of a variety of the most recent statistics and other material on personnel in the mental health field not heretofore available.

In the introduction the reader will find a well-stated outline of the problem of social and mental pathology in the United States and implications for service needs in the population trends over the next two decades. The growth of the several professions now seen as central to meeting the need for mental health services is treated historically and there is a detailed accounting of the numbers and distribution geographically of psychiatrists, psychologists, social workers, and nurses over the country. A wealth of tables in the appendix provide graphic illustration of this section of the report. We learn, for example, that "In the fifteen states above the national average in the ratio of psychiatric social workers to population, there were twenty-three schools of social work with psychiatric [social work] training. In the thirty-four states below the national average, there were only fourteen schools of social work" (p. 146). For all the professions it is obvious that graduates tend to cluster around the training centers, and, as a result the states with the most training resources have the most trained people. The report recognizes the benefits emerging from the work of regional educational bodies which are doing much to promote improved and expanded training resources.

In covering the various types of personnel, the author assesses the contribution of psychoanalysts in the total training picture. Likewise, he includes chapters on medical education and on personnel categories more peripheral yet important to mental health programs—the occupational therapists, the clergy employed in mental health, the psychiatric aides, and the practical nurses. More of all of these are needed, too.

One can understand why the situation is regarded as complex when the intricate interlocking and cumulative impacts of one field on another are seen. In the chapters on medical education and general education the reader becomes deeply aware of the futility of expectations that education for

the mental health professions can be expanded in any substantial way unless there is first found some means of fostering improvement and expansion in medical education (as basic to increasing the numbers of psychiatrists) and in general education (to provide a larger and better trained pool of students for all the professions). The critical need for more and better teachers and for a truly adequate system of scholarship aid at the undergraduate and graduate levels clearly points to the glaring deficiency of the current efforts to remedy the situation in education. Albee sounds the alarm for all to hear.

The chapter on social work expresses succinctly the typically dismal prospect when one compares the slowly increasing numbers of graduates (2,500 estimated by 1965) with the concurrently larger increases in the number of graduates needed (estimated at 12,000 a year). The growth in psychiatric social work, while occurring at a more rapid rate than in other fields of social work practice, still is far from meeting the

known needs for personnel in hospitals, clinics, and elsewhere. Albee correctly explicates the relation of all social work to mental health. "A good case can be made for the argument that every social worker is crucial to problems of mental illness and health. In their concern with alleviating or preventing crisis in human lives social workers are mostly concerned with the alleviation of the very problems we have said define mental health" (p. 141). This suggests that the manning of social welfare programs has important supportive implications for mental health and should receive a high priority in state and national planning.

The report proposes a group of "solutions" for the manpower crisis. Social workers will find it worth careful reading as it touches on issues and problems which deeply affect the structure and function of the field as it is now organized.

MILTON WITTMAN
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Book Reviews

FAMILIES IN TREATMENT. By Erika Chance, Ph.D. New York: Basic Books, 1959. 234 pp. $5.50.

The results of five years of research centering around 34 families seen in therapy at the Child Study Center, Institute of the Pennsylvania Hospital in Philadelphia, form the basis of this book. The author, a psychologist, has presented her material in two parts. The first section is a discussion of some problems in research stemming from differences in values and conceptualization between clinicians and researchers. This section of the book underscores the fact that research on the treatment process demands accommodations from both parties which represent changes in the usual clinical or research routine. That such accommodations may have unexpected benefits is exemplified in this study by the workers' reactions to having therapy sessions electrically recorded. After an initial period of uncertainty about this change in practice, the workers come to view these transcriptions as an aid in studying their own treatment techniques.

The second section of the book reports the research proper which is concerned about how families in treatment and their therapists reacted to and perceived the treatment process. Although psychiatrists were therapists for the child, and social workers were therapists for the mothers, the primary findings center about six social workers and their clients. As the author observes, it is important to recognize that this research is an exploratory study rather than a formal investigation designed to answer specific questions about therapy for families. Thus, no control groups have been used. The small sample size (19, 6, or 1 depending upon whether you focus on the families, the workers, or the agency) precludes adequate analysis of comparable subgroups. The families are relatively homogeneous, coming predominantly from Jewish, white collar, and professional backgrounds. Despite these limitations, social

workers concerned about family treatment should find provocative some of the hypotheses suggested by this work. Do experienced and inexperienced workers differ in their expectations of changes in clients' behavior? Do psychiatrists and social workers emphasize different goals in treating the same family? How do parents' perceptions of changes in treatment jibe with the changes perceived by workers? As the number of joint efforts by researchers and clinicians grows, we look forward to more systematic answers to these and other questions to aid our understanding of family dynamics and the therapy process.

JAMES BIERI

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THE CHANGING AMERICAN PARENT. A Study in the Detroit Area. By Daniel R. Miller and Guy E. Swanson. New York: John Wiley & Sons, Inc., 1958. 302 pp. $6.50.

As a profession emerges from an era when beliefs suffice into one when knowledge becomes an imperative, it faces critical choices: What knowledge? How combined? How used? Social work in the period of its emergence from the status of a social movement into a profession had to make such choices. In the presence of a disunited, segmented science of man, the early social work professionals first chose economics, then sociology. Mary Richmond, some of her predecessors, and also her contemporaries, searched the writings of economists and sociologists for the facts with which to fill their professional kit of knowledge. This choice of the social was soon relinquished in favor of another kind of one-sidedness— the psychoanalytic. During both of these eras, but especially during the latter, the practice of social work seemed to rest precariously on a one-footed stool. The position, though seemingly economical, was nonetheless discomforting. It was, therefore, with considerable enthusiasm that social work seemed to embrace the more social

neo-Freudians, the psychological sociologists, and the social psychologists, who brought with them some unity of the psychosocial and insights as to the unavoidable relationship between the two.

The present volume by Drs. Miller and Swanson shows an effort to relate the psychic to the social—the changing demands of a social system and the implications they carry for the process of rearing the child. The authors first review with considerable care what they designate as four major periods of child-rearing practices in the United States. The practices of each period seem internally consistent and related to the expected and valued attributes in the socially mature adult. The child is reared to meet the needs of the day.

This review of societal needs and parental behavior, and the relation between the two, leads to the major question of the research upon which the book is based: What are the societal demands of the immediate past and the present, and how do they relate to changes in child rearing? The authors posit a number of hypotheses—the major one of which is that American society, in changing from entrepreneurial to welfare-bureaucratic, requires a new kind of man, whom mothers train from the cradle onward. The man of yesterday, who is still to be found in today's America, was a combination of self-control, of an inner-based sense of values, and of an ability to manipulate the environment. He was self-made and self-directed, and from the earliest these virtues were built into him. Today's man —and increasingly tomorrow's man—requires different qualities. Functioning largely in a benevolent and secure private or public bureaucracy, he may not be so self-assertive as he must be accommodating. To preserve his security which he cherishes, he must defer to the values about him. Being markedly more assured of the future than his entrepreneurial predecessor, he need not deny himself the pleasures of today for the rewards of the morrow. The welfare-bureaucratic man is "other-directed" and "con-

sumption-oriented," to use Riesman's terminology.

The authors test these and a number of related assertions by surveying a substantial sample of mothers in Detroit, Michigan. Unlike so many studies of child care, this one is well-designed and conducted. The sample is randomly chosen to represent all families in the Detroit area. The analysis of data is thorough, and the interpretation is made with the care and caution it should have. Especially impressive to this reviewer are the controls introduced in testing the likelihood of causal (or time-sequential) relationships as, for example, between entrepreneurial fathers and the child-rearing practices employed by their wives. Repeatedly, the authors ask, in effect: "Very well, the relationship exists but what happens to it when we control the groups for education or country of nativity, for example?" Also impressive, although not unanticipated, is the avoidance of an error still so common in the social sciences, namely, the assumption that significant relationships are *all* those found by performing myriad association tests of two variables at a time. The authors not only avoid falling into the pit, but they mark it with clarity for the reader.

The book has many merits. For the practitioner, it contains a careful description and interpretation of child-rearing practices and their relation to societal needs. For the researcher, it offers numerous new leads and apparently fruitful hypotheses. For the theoretician, it offers yet another step toward the integration of personal and social phenomena in a common framework. It is a well-written and carefully thought-through book which conveys scholarship and good research in simple language and with the seeming ease which is the result of hard labor over a considerable period of time.

MARTIN WOLINS

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FAMILY WORLDS: A PSYCHOSOCIAL APPROACH
TO FAMILY LIFE. By Robert D. Hess and
Gerald Handel. Chicago: University of
Chicago Press, 1959. 305 pp. $5.00.

By chance, this book was read in close
proximity to *An Anthropologist at Work*.
Thus it was not by chance that the interest
which accrued while reading *Family Worlds*
brought to mind the pleasure derived on
first acquaintance with *Patterns of Culture*.
On returning to it to substantiate these
recollections, many similarities were dis-
covered in both the descriptive and
theoretical chapters that provided evidence
of an affinity between these two books. The
following sample, which states some basic
precepts pertaining to the inquiry and
observation of human experience, is quoted
here as testimony but also as an introduction
to *Family Worlds*:

> The field worker must chronicle all the
> relevant behavior, taking care not to
> select according to any challenging
> hypothesis the facts that will fit a thesis.
> [In these studies] . . . the ethnology was
> set down as it came, with no attempt to
> make it self-consistent. The total pictures
> are therefore much more convincing to
> the student. In theoretical discussions of
> culture, also, generalizations about the
> integration of culture will be empty in
> proportion as they are dogmatic and
> generalized. We need detailed informa-
> tion about contrasting limits of behavior
> and the motivations that are dynamic in
> one society and not in another.[1]

This quotation is an especially apt
introduction since it is difficult when trying
to state what a book is about and why it
might be helpful to whom, to convey the
spirit and quality of inquiry which is
manifest in the data as well as in the use
that was made of the material. At the time
this book was written, the authors were both
associated with the Committee on Human
Development at the University of Chicago.
Here, they developed and carried out a
research project that was concerned with
the study of "ordinary families" as intimate

[1] Ruth Benedict, *Patterns of Culture* (Penguin
Books, 1946) p. 211.

groups of persons that function in a system-
atic way. In focusing on the internal
processes of family life "which have more
frequently been the province of psychol-
ogists, psychiatrists and social workers,
treating persons with psycho-clinical dis-
orders," their aim was to depict what it
feels like to the actual individuals who
shape life in an intimate group. In addi-
tion they were also concerned with devel-
oping a framework for understanding the
nuclear family as a group. Altogether,
thirty-three families were included in the
study and five of them are presented in the
case studies that constitute the major por-
tion of this volume. The research methods
are described in an appendix.

In the first and last chapters of the book,
there is discussion of five major processes
that were identified as giving shape and
coherence to the flux of family (group)
life. They are (1) establishing a pattern of
separateness and connectedness, (2) estab-
lishing a satisfactory congruence of images,
(3) evolving modes of interaction into
central family concerns or themes, (4)
establishing the boundaries of the family's
world of experience, (5) dealing with
significant biosocial issues of family life—
evolving the family's definitions of male
and female, of older and younger.

Considered in their own terms—that is,
as ideas—these five processes constitute
interesting refinements of what many of us
referred to for some years as *the* group
process. When they are read and in a
sense experienced in the context of the lives
of these five families, their usefulness is
demonstrated in a number of absorbing and
stimulating ways. Thus, it seems certain
that this framework will be of value to those
persons who are currently concerned with
the formulation of theory that is pertinent
for social work with groups. It also seems
possible to anticipate the use of similar
ideas in the intake process in group service
agencies, as well as in the study of foster
families and the placement of children in
them. For both current interest and future

reference, it should be noted that these five concepts are not reiterated in an identical way in each of the case studies. Instead, the authors have elaborated on different aspects of these processes in order to illuminate particular aspects of the life and activity of each family. They have put their emphasis on presenting the contrasts in the interactional processes in these families rather than on the development of a typology. This aim is maintained throughout the book and begins with the Table of Contents. Here the five families are presented by pseudonym and by means of subtitles that provide clues to the ways in which they cope with the central conflicts in their lives, for example, *The Clarks—Flight from Insecurity; The Lansons—Equanimity and Its Vicissitudes; The Steeles—Comforts and Crises of Companionship.*

Of the five "ordinary" families or five variations of familiarity which the case studies elucidate, the Lansons may be of especial interest. Others may share the reviewer's curiosity concerning the exploration of equanimity. What does it cost, *i.e.*, what are the cross-currents underneath the calm surface of this family's life?

The case studies taken as a whole, merit further comment. In the first place, they demonstrate the authors' concern that their concepts not become detached from the phenomena that they are intended to represent. Second, they will undoubtedly be (to return to Ruth Benedict) "convincing to the student" in ways that stimulate reflection and clarification of their own life experiences, and evoke increased curiosity about the life experiences of their clients, patients, or "members." Furthermore, the remarkable use of detail, plus the careful and imaginative analysis of the data, communicate the authors' thought processes in a way that makes possible direct transfer of experience and brings to mind the popular distinction between learning that is caught rather than taught.　　　HAZEL OSBORN

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Who Are the Guilty? A Study of Education and Crime. By David Abrahamsen, M.D. New York: Grove Press, Inc., 1958. 340 pp. $1.95.

Dr. Abrahamsen has written a book of substance and usability in this work, which deals with the behavior and personality of the criminal. While it represents many years of his work as a practicing and research psychiatrist in the criminal field, there is also considerably more than the recital of psychiatric events, since in his own words, "This book constitutes a broad mental hygiene plan based upon educational aspects and represents a synthesis of our present knowledge about the relationship between the human mind and delinquent activities."

It is Suzanne K. Langer who says in her volume, *Philosophy in a New Key*, that the essential task of philosophy is the formulation of the problems of each age. Dr. Abrahamsen has not only dwelt with a major problem in American life for many years, but as a practitioner he has gone beyond the philosopher in presenting a vigorous psychological and educational approach, psychoanalytically oriented, for the greater understanding and treatment of the criminal and the delinquent life. His use of case material is not alone varied and illustrative. It is again and again revealing of his major thesis, namely, the criminal is the product of irrational and unconscious forces which must be attacked at the source if rehabilitation is to come. In this respect alone the book deserves to be on the "must" shelf of the correctional field, and it has broad applicability for workers in probation, parole, and institutions which are charged with the daily responsibility of assisting and directing the criminal toward socially approved patterns.

Dr. Abrahamsen further writes, "There is the same connection between the criminal and his acts as there is between any man and his acts." And he makes effective and frequent allusions to this equation via the case material provided. It is also heartening to hear, "A neutral attitude on the part of the analyst toward offenders in general will in most instances have an unsuccessful result on the patient." This last, together with the work of Melita Schmiddeberg and some of our current social work literature concerned with the hopeless and hard-to-reach families, are for this reviewer very encouraging indicators of greater movement toward the troubled person, as contrasted with traditional practice.

In the area of broad social correctives, the author calls for a National Research Institute for treatment of the offender and his family members and for the teaching of psychopathology to law students. He makes a broad plea for the training not only of those disciplines traditionally identified with the criminal problem but also the specialized training of educators, clergymen, teachers, anthropologists, and sociologists. Finally he proposes full community mobilization for a truly effective handling of the problem.

While the author never attempts to give a direct answer to the question contained in the title of this book, there is sufficient opportunity for the reader to make his inferences, particularly as revealed in the last chapter of the book. This work is also a most welcome addition to the psychiatric and social work literature in criminology, which continues to be too small both in interest and volume. A greater interest on the part of the several healing disciplines is clearly indicated and has for many years lagged behind other professional interest areas. The book carries, too, an abundant and rich bibliography for those professionals who are in search of a fuller understanding of the criminal mind and the various approaches which have been taken with regard to the criminal problem.

Louis S. Bershen

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CASEBOOK IN CORRECTIONAL CASEWORK. Prepared by the Committee on Corrections for the Committee on Teaching Materials. New York: Council on Social Work Education, 1958. 66 pp. $2.00.

Oscar Wilde, in one of his more trenchant observations, referred to a foxhunt by the British landed gentry as a pursuit by the unspeakable of the uneatable. In view of the long-standing suspicion until relatively recently by correctional officialdom of social work practice and the reciprocal disdain of social workers for practice within an authoritarian setting, the allusion enjoys a peculiar appropriateness. It is heartening and gratifying, therefore, to examine a publication especially prepared by the Council on Social Work Education as a training instrument for caseworkers interested in the field of corrections. Aside from the merits of this brief document—and they are considerable—it represents an acknowledgment of the coming of age of correctional casework.

This interesting and significant casebook was prepared by a special interdisciplinary panel of two social work educators, two sociologists, and a psychiatrist, convening at the School of Social Welfare of the University of California in Los Angeles. The material from which the cases were compiled was examined and studied by many groups and individuals since 1951. The book itself is divided into three sections: a remarkably succinct section on the framework of contemporary correctional practice, a section with two sets of case records with study outlines, and a bibliography which, in the estimation of this reviewer, is the most disappointing part of the work.

The initial section which deals with the organization, structure, and some of the principal problems of the correctional field, is one of the most impressive statements of its kind that this reviewer has read. For a field of such complexity and such contravening and controversial opinions, it is remarkable to see how much the committee has been able to concentrate within a few pages. Equally impressive is the facility and clarity of expression of difficult issues in a profession where clarity of expression is not always apparent. This statement of program and theory is deeply cognizant of the need to recognize the implicit assumptions for treatment imposed by different, and frequently opposing, disciplines. The need to recognize such assumptions is not only the token of maturity in any profession but is deeply suggestive of the need to find significant reconciliation of divergent views within a common framework. It is reminiscent of Lewis Mumford's cogent observation that, in the present-day world, we need a new type of mentality which can encompass a number of divergent variables at the same time. In a small way, an attempt such as this, if it is fully recognized and accepted by a professional group, can constitute a small landmark in this direction.

After careful stipulation of the nature of the correctional task, and wrestling with the captious problem of definition of delinquency and criminal behavior (almost a superhuman task today), and the several interrelationships of correctional agency to the community, the client, and the worker, the introductory section does a masterful job in delineating some of the major classifications of correctional clients. The identification of the sociopathic individual, the so-called "normal" offender, the neurotically oriented, and the psychotic, within the space of a few pages, is highly suggestive. One is led to hope that, aside from its value to potential caseworkers in corrections, the intriguing analysis of the dependency relations of the correctional client might become a preface to action for correctional officials generally. If this could be vouchsafed, then it would seem merely a matter of time before our detention centers, penitentiaries, and prisons might truly become centers for therapeutic action.

The sets of case records represent a fairly adequate sampling of the range of problems

with which the correctional caseworker
comes to grips. Ranging from problems of
probation intake to problems of adult
institutionalization and adult parole, the
newcomer to the field can begin to perceive
how the specialized aspects of correctional
service function, and the character of over-
lapping as well as exclusiveness of perform-
ance. This reviewer, however, must admit
that he was somewhat puzzled by what the
committee chooses to regard as "study
outlines" appended to each case. For the
most part, these "study outlines" merely
consist of a few broad questions to be
covered as a basis of discussion. This may
be in accord with what the social work
educator regards as sound educational
practice. However, one of the earmarks of
a profession which is coming of age is its
capacity to structure its professional mate-
rials far more carefully, particularly in
view of the recognized variations in the
assumptions for interpretation coming
from different disciplines. Nevertheless, in
a profession which has been somewhat
behindhand in recognizing the significance
of the area for which this casebook was
prepared, one should be grateful for all
favors received and perhaps not overly
captious at this stage.

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AN EXPERIMENT IN MENTAL PATIENT RE-
HABILITATION. By Henry J. Meyer and
Edgar F. Borgatta. New York: Russell
Sage Foundation, 1959. 114 pp. $2.50.

This book is the result of an attempt by
two social scientists to apply rigorous exper-
imental methodology to the evaluation of
a sheltered workshop rehabilitation pro-
gram for post-hospitalized mentally ill
patients. Altro Rehabilitation Services
Inc. in New York City submitted itself to
the scrutiny of research investigators who

wanted to know what the impact of this service was on the community. They questioned if those who received Altro services would "be better rehabilitated" than those who did not, but warned that such findings were not to be interpreted as a statement about "the specific program offered by Altro." The two-year study was sponsored by the Russell Sage Foundation which for years has had a continued interest in research on programs for the mentally ill.

Altro, primarily a rehabilitation center for tuberculous and cardiac patients, had conducted a modest experiment in providing noncompetitive work experience for ex-mental patients of Hillside Hospital. The promise of this small-scale operation, led Altro to expand in this area. Psychiatrists and other mental health professionals had assured Altro of the need for such a service and of the community demand for it. On this basis, arrangements were made with the Bronx Aftercare Clinic to develop a target population from which Altro samples could be obtained. The patient flow into Altro was very small. A sample of 81 was finally obtained, 41 patients to participate in the Altro program, and 40 for control purposes. The backgrounds of both groups were studied and a follow-up study was conducted to test the effectiveness of the Altro program.

So far as an evaluation study goes, the authors themselves admit to not being "wholly successful," but this is not to their discredit. In fact, they have provided a wealth of information on the problems of evaluation research and have reassured us of the need for these studies to be carried out systematically in the broad framework of alternatives of services that are available in the community. In assessing a service, "it is not sufficient to determine that an agency's program is better than neglect." They have also raised questions of importance for the field of social welfare in general, such as untested assumptions connected with demands for services and availability

of persons to use those services. Because of these broad questions affecting the field of social service, this book will be of importance to researchers and administrators in addition to providing useful information to psychiatric social workers.

ELENA PADILLA
*New York City Community Mental
Health Board*

PILOT PROJECT, INDIA. By Albert Mayer and Associates in collaboration with McKim Marriott and Richard L. Park. Berkeley and Los Angeles, California: University of California Press, 1958. 367 pp. $5.50.

This book is a comprehensive report on the origins, philosophy, and methods used at Etawah, a pilot program for rural development in India. The project, an early example of the "movement to raise the levels of living of vast rural populations in Asia and Africa and give their lives enhanced dignity and worth, . . . eventually became a prototype for Community Development Projects and National Extension Service Blocks in thousands of villages in every part of India." Mr. Mayer, an architect and town planner who first visited India in 1942, has drawn primarily on reports, memoranda, and correspondence written between 1946 and 1955 while he was adviser and "catalytic agent" for the program. His approach, while presenting material vividly, makes for some repetition and disorganization, particularly in the early chapters. However, the growth and development of Etawah which ultimately included over 300 villages is shown in considerable detail. Well-written case histories, vignettes, anecdotes, and personality sketches not only illustrate Indian village life dramatically but also show the myriad difficulties of encouraging change with the active participation of the village and "without breaking up the old foundations." Organizational problems, staff training, and specific techniques of rural work as well as results, implications, the need for research and future plans are discussed.

This book will be of interest to all concerned with the vast majority of the world's population who still live in poverty and poor physical health. For those specifically involved with community development programs it will provide valuable source material and guidelines. For social workers increasingly aware of international responsibilities the illustrative material provides excellent examples of life in rural India and also suggests ways that the profession may contribute to the underdeveloped nations. In many of the chapters, particularly Chapter V where an "unusual program of arousing and involving the people" is described, many familiar concepts will be found. Although the authors comment that this "book itself grew out of mutual seeking between the interests of Social Science and action," there seems to be no recognition of the existence of social work as a profession which might add to this "mutual seeking." This reviewer does not believe that community development is synonymous with social work, nor with community organization as a method of social work. However, it is believed that many of the techniques used in community development programs are remarkably similar to methods which professional social workers have used effectively under varied conditions and with varied peoples. Thus social work has an important role to play in the future of community development; this role is ably examined in Chapter 4 of *Training for Social Work, Third International Survey*, published by the United Nations in 1958.

Mr. Mayer's courage, honesty, clear thinking, and understanding of the complex problems of India are clearly reflected. His ability for critical evaluation of progress is evident and his realistic appraisal of the past and the present as well as his concerns for the future are ably expressed in his final chapter on "Problems of Expansion."

HELEN PINKUS

*Smith College School for Social Work
Northampton, Massachusetts*

Book Reviews

MENTAL SUBNORMALITY. By Richard L. Masland, Seymour B. Sarason, and Thomas Gladwin. New York: Basic Books, Inc., 1959. 442 pp. $6.75.

The multiplicity of factors that cause mental subnormality in approximately 150,000 children born annually in this country is of vital concern to parents, to scientists, and to the many helping professions that must deal with its manifestations. The isolation of these factors is of crucial importance in the development of sound programs of prevention, management, training, or treatment.

By many standards, this book is one of the most authoritative and exhaustive summaries of contemporary knowledge and basic research on the causes of mental subnormality in today's literature. Recognizing that two broad areas of study needed to be considered, widely differing approaches were used to insure reasonable coverage. Dr. Masland's survey investigated those factors which produce anatomical or chemical abnormalities of the nervous system and result in defective brain functioning. Drs. Sarason and Gladwin have reviewed research on the cultural and environmental factors which inhibit optimum intellectual functioning in a person whose nervous system is basically capable of normal activity.

Despite the dichotomy of this approach—essential for research—the interrelationship of biological and environmental factors is not overlooked. In fact, each author concludes that mental subnormality cannot be fully understood on the basis of biological or environmental influences alone. Also of considerable importance to practice is the attack of both reports on the damaging and immobilizing concept that heredity is the basis for most forms of mental retardation. Stress on the dynamic components in this complex condition and its susceptibility to change in many cases through therapeutic procedures is one of the outstanding contributions of this document.

The material presented in these pages would be of value to social workers in almost every phase of practice. For those in hospital or clinic settings or in agencies serving children who are neglected, dependent, or delinquent, this book is invaluable.

The report by Dr. Masland is of a highly technical nature and would have limited application to social work methods. Nevertheless, it provides an essential dimension to an understanding of mental retardation and to a fuller awareness of the relationship between physical and psychological factors in the development of the total personality.

Many of the studies reported, relating to sociological and cultural influences, though not specifically directed toward mental retardation, have significant bearing on the subject under discussion. Because of this comprehensiveness, this section contains important implications for understanding the development and structure of intellect in normal as well as handicapped persons.

Social work has a unique responsibility for the underprivileged, and for the psychologically and culturally deprived members of our society. Our success in alleviating the problems these people present rests to a considerable degree on an understanding of the individual's interaction with the larger social forces in his environment. The book contributes significantly to an understanding of these forces.

MICHAEL J. BEGAB

Children's Bureau
Washington, D. C.

CORRECTION

The editors regret the misspelling of a reviewer's name on page 119 of the October 1959 issue. The reviewer of *Patients Are People* by Minna Field (second edition) was Freda Goldfeld of Beth Israel Hospital, in New York City, *not* Freda Goldfarb. Our apologies.

TOP LEADERSHIP U.S.A. By Floyd Hunter. Capitol Hill, North Carolina: University of North Carolina Press, 1959. 268 pp. $6.00.

Readers of his earlier writings know that Floyd Hunter has a deep interest in community power structure. He reports that in every community he studied there has been a well-defined group of people who constitute a power structure. These top leaders are related to men who move in co-ordinated ways and still to other men who "get things done" or "stop things from getting done."

In *Top Leadership U.S.A.* the author applied a method for studying the relationships of men in power. In this book, which is a series of studies, he visited, during a five-year period, all major and many smaller cities in the United States and interviewed community leaders, American and Japanese textile leaders, housing leaders, and elected officials designated by their peers as top leaders in establishing policy and decisions. Mr. Hunter points out that there is a power structure inside and outside of government in the development of national policy. State leaders, corporation executives, and professionals in associations are involved in policy formation. The author pursues this in his more detailed description of power to the specific housing and textile industries.

The methodological steps are detailed with adequate explanation. The questions of presence of a power structure at the national level of affairs as in local community was pursued by ascertaining names of top leaders and their identification, from national agencies. Those selected as top leaders by their peers were interviewed and questioned about the relationships to each other, the influence of their associations on policy-making at local, state, and national levels. A great many of the leaders mentioned were businessmen but others were educators, social workers, government officials, and clubwomen. The interviews recorded were, in many cases, detailed, quite frank, and revealed that many of the

people knew a lot about each other. These interviews also showed how some people operate, organize, and advance causes. The question of how these men act together to influence policy was pursued in a special study in two states, North Carolina and South Carolina. The textile industry in the latter, for example, revealed that state textile leaders' influence was evident in specific national policies in the textile industry.

The author revealed that the formulation of national policy and its execution were processes in a structure of action not unlike that found in local community power situations. He describes the general steps taken in the development of a given national policy, as well as guiding principles utilized by those ultimately responsible for policy decisions. The nation's power system is a series of interlaced and co-ordinated power structures. He reveals that people in power in the community, state, regions, service organizations, and industrial complexities are generally known to each other.

This book, or series of studies, should be of real interest and usefulness to social workers and social work educators. It should be particularly useful for teachers of courses in group process, administration, research, and community organization.

LEO F. FRIEL

*United Community Services
of Metropolitan Boston*

A CLASSIFIED BIBLIOGRAPHY FOR THE FIELD OF SOCIAL WORK. By Leo W. Tighe. Santa Clara, California: Premier Publishers, 1959. 235 pp. $4.00.

The burgeoning forest of social work literature and related materials of interest to social workers has long since defied casual bibliographic handling. Social work educators, students, and researchers particularly have been troubled by the absence of a comprehensive source of information on the published materials relating to their many interests.

In a modern-day pioneering effort to develop a bibliography that is "designed to be useful to all who are interested in the field of social work," Professor Tighe has provided a compilation that should indeed find many users. He has sought not only to prepare a listing covering a large segment of social work literature, but also to systematize the coverage according to a classification scheme well known to most social workers.

The bibliography consists of two major parts, one on counseling and guidance and one on social work. The former is classified under 36 subject headings. The social work part, representing about 85 percent of the total number of listings, is classified under 56 subject headings, some of which are subdivided. This part includes listings of books and one or more articles from 115 journals in social work, psychology, education, medicine, and related fields. Listings under each subject heading are alphabetical by author's name and contain the title, journal (or publisher for book listings), volume, date, and page references. No annotations are provided.

The classification scheme used in the social work part is not unlike that of the *Social Work Year Book*. The journal articles listed include publications dating from the early 1940's. Books, government documents, and pamphlets listed include publications from the early 1930's. Both the counseling and guidance parts contain separate sections listing audio-visual materials.

While the bibliography will provide a much-needed ready reference to an apparently large segment of the literature of social work, there is no clear indication of the extensiveness of its coverage. Without indication of the time span covered by the journals from which listings are drawn, the criteria used in selection of listings, or the library resources employed in identifying listings, the bibliography user is uncertain about the need for further investigation to obtain a required coverage. Although some of the classics of social work literature are omitted, there is no statement of the rationale for their omission. The relationship between the guidance and counseling part and the social work part is not stated.

No bibliographic listing is included under more than one heading, nor is any cross-referencing provided. Because of the likely relationship of each listing to more than one of the subject headings used, it is necessary that the bibliography user examine the materials under several headings in order to explore any area of interest. The addition of cross-referencing would further enhance the usability of the bibliography, as would the inclusion of an author index.

The classified bibliography represents a sizable step forward in the task of providing systematic access to the literature of social work. It will be of considerable value to anyone initiating a search of the literature in the field.

GEORGE K. HERBERT

Community Council
Houston, Texas

CURRICULUM STUDY

Just a note of thanks for your great editorial in the October issue. I wish every "reader" of the study had as open-minded a view.

Incidentally, we are not recommending that inexperienced students enter into administration, community organization, or research practice. Rather, we are making the selection of students into these curricula an aspect of the advising process with the expectation, of course, that experience would be one of the criteria for selection. The establishment of the criteria for selection should be a matter left to the discretion of each school (this internal admission process is not unlike that of some of the professional programs, *e.g.*, clinical psychology and public health).

WERNER W. BOEHM

University of Minnesota
Minneapolis

CONTRIBUTIONS OF ADC MOTHERS

One sentence in Ruth Chaskel's article, "Public Social Policy and Casework Services in Public Welfare" (July 1959) startles me. That in effect Aid-to-Dependent-Children mothers are . . . "a group beset by a multiplicity of problems to themselves and to society and out of step with the community in whose midst they live but to which *they make little positive contribution.*" Some of us who administer ADC programs have been working under the impression that raising a child is perhaps one of the most positive contributions anyone could make in any society anywhere!

J. CLARK KELLETT

Director, Brown County Welfare Board
New Ulm, Minnesota

ALIENATION BY RECRUITMENT

Erma Meyerson's article, *The Social Work Image or Self-Image?*, in the July (1959) issue of the journal inspires me to personal reminiscence about the particular recruiting appeal that some twenty-nine years ago alienated this correspondent from the proper approaches to a social work career. The fact that I, like so many others, soon after bootlegged my way into social welfare through the backdoor of emergency relief only goes to prove that a natural candidate was missed by an "image" that did not fit my aspirations.

I happened to graduate from college in 1931, a year when unemployment approached the ten million mark, when Herbert Hoover was pleading for a widespread application of the power of positive thinking to the restoration of the *status quo ante,* and when institutional provisions to cope with social and economic calamity on this scale were nonexistent. Private "charity organization societies" and local Poor Law agencies were desperately trying to hold back a flood of misery with resources far short of the mythical Dutch boy's fist. Naturally, like all earnest young people of the day, I was alarmed and confused by the collapse of social and economic values that only two years before had seemed as firmly entrenched as the Rock of Gibraltar. To me the field of social welfare seemed clearly involved; with surprising prescience I even wrote my senior thesis on a then revolutionary if not actually subversive idea, "The Federal Relief of Unemployment."

Upon this scene in due course arrived the hucksters for various careers (and in 1931 we blue-stocking females were *very* career-minded), including an attractive and well-known lady social worker who besought our enlightened consideration of the profession. The image she presented, though surprisingly up to date considering the lapsed time, failed dismally to arouse me and I wonder if I do not have contemporary counterparts. She too was concerned lest we confuse social work with the giving of handouts. "Of course," she explained, "a good caseworker will occasionally use economic aid as a part of the treatment process. But *this* is not social work. To understand

the real nature of social work you must remember just these five words: 'Social work is *changing attitudes.*' " Personally, I did not want to "change attitudes"; in that setting it seemed to me a patronizing and judgmental approach to the major social miseries of the day. I wanted to help create and maintain a society where people would not have to be hungry, jobless, sick, neglected, or forgotten and no hint was dropped to me on that occasion that social work might have some part in this process.

Since that time I must have read or listened to at least a hundred thousand words elaborating on the approximate thesis of the social worker of my youth. But I still think it lets a derivative and by no means universal aspect of social work obscure the true and unique grandeur of a social function recently described by a group of international experts as "organized activity that aims at helping toward a *mutual* (italics mine!) adjustment of individuals and their social environment." It is almost as if recruitment for the ministry, priesthood, or rabbinate, for example, stressed the values of a single ministerial function like, say, leadership of communal prayer without reference either to religious conviction or its institutional embodiment in church or synagogue. Of course social work involves relationships to individual human beings in circumstances which inevitably have subjective as well as objective factors. This is one of its great attractions to those who enjoy direct contact with people. But it also has a social purpose and an institutional framework; the social worker is an agent of society, helping to facilitate its functioning in terms of individual welfare.

I am one of those who enjoys the institutional aspect of welfare. Within two years of graduation I had trekked to Washington, along with thousands of other young people aroused by the social upheavals of the New Deal, and was working for Social Worker Harry Hopkins at an unprecedented social welfare task in which "chang-

ing attitudes" played almost no role at all. This federal relief program, together with the more permanent social security program which followed it, were the product of profound institutional changes in which crusading social workers played an important part.

Luckily "social action" and concern with social policy are coming back into fashion in social work circles. But it does seem to me that in recruiting social work consistently undersells itself by de-emphasizing its *social* role, its contributions to the better functioning of the social order itself. For those young people whose primary interest lies in helping other individuals on a person-to-person basis, many other professions offer attractive competition: medicine, nursing, psychiatry, teaching, the ministry and other religious callings—to name a few. But where is the young person supposed to turn who is interested in the *relationship* between the social order and the individual, in using the resources of society to answer

human need and the firsthand knowledge of human need to improve the social structure? This is the special province of social work and I believe it is here that our appeal to young people could make its strongest case.

ELIZABETH WICKENDEN

New York, N. Y.

Thank you for Erma Meyerson's article on the social work image. Perhaps you could encourage some of our professional publications to head a reform movement! During the past year one of them, in telling of a valuable convert to the profession, quoted a statement of approval to the effect that she was not the sort of woman who wore low heels. In this era when most of us own at least one pair of low heels I am sure it would tax the intelligence of even the class valedictorian to figure out the correlation between the height of your heels and your diagnostic skills.

It has been my experience that the most

helpful caseworkers are those who are client-conscious rather than clothes-conscious.

Thank you for giving us such a fine publication. HELEN MACKENZIE

Family Service Association
Lorain, Ohio

SANE NUCLEAR POLICY

The statement of the Social Workers' Committee for a Sane Nuclear Policy in your October (1959) issue is most encouraging and worthy of support by social workers throughout the country.

It seems more than timely that social workers are at last taking a stand on the vital human issues envolved in nuclear explosions. Perhaps the New York committee has taken the step that will lead our profession back to its traditional role of responsibility for such difficult and demanding causes. RUTH SPIEGEL

Burbank, California

HARD-TO-REACH AGENCIES

I wish to express my deep appreciation of the article in your October (1958) issue by Ruth Ellen Lindenberg "Hard to Reach: Client or Casework Agency?"

For some years I have worked in the Family Court of Cook County (formerly Juvenile Court). Little by little I have seen the agency resources available to our clientele shrinking. More and more I have seen the difficult cases dumped on public agencies whose workers carry an overload. Those of us struggling with the problems of our clientele become somewhat cynical as agencies limit their intake to "those where we can give the greatest service."

It is quite refreshing to pick up a professional magazine where this point of view on the part of agencies is challenged. I presume it is too much to hope that many professional workers will be influenced by Miss Lindenberg's article. IRENE KAWIN

Circuit (Family) Court
of Cook County, Chicago